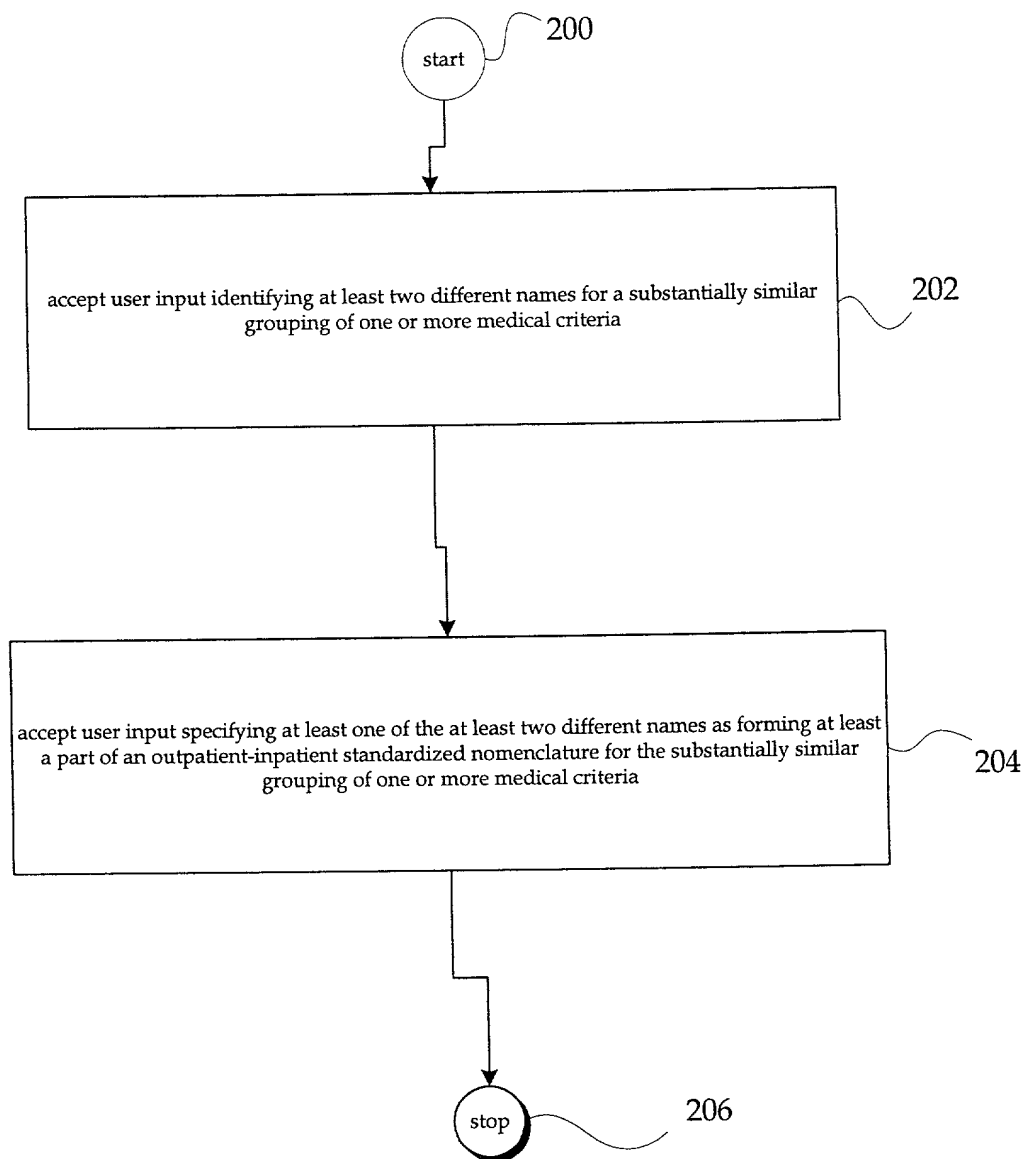
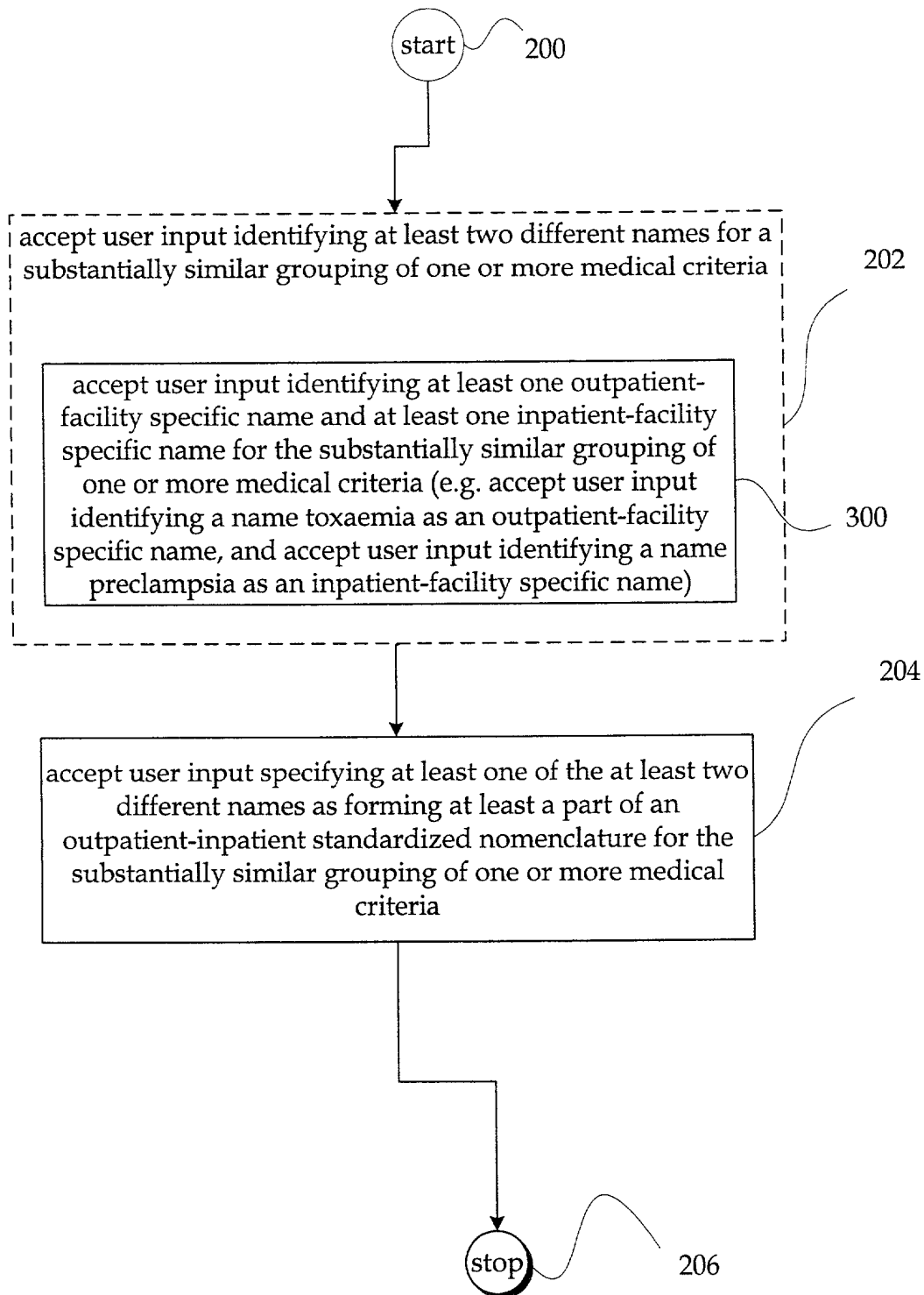


Fig. 1

*Fig. 2*

*Fig. 3*

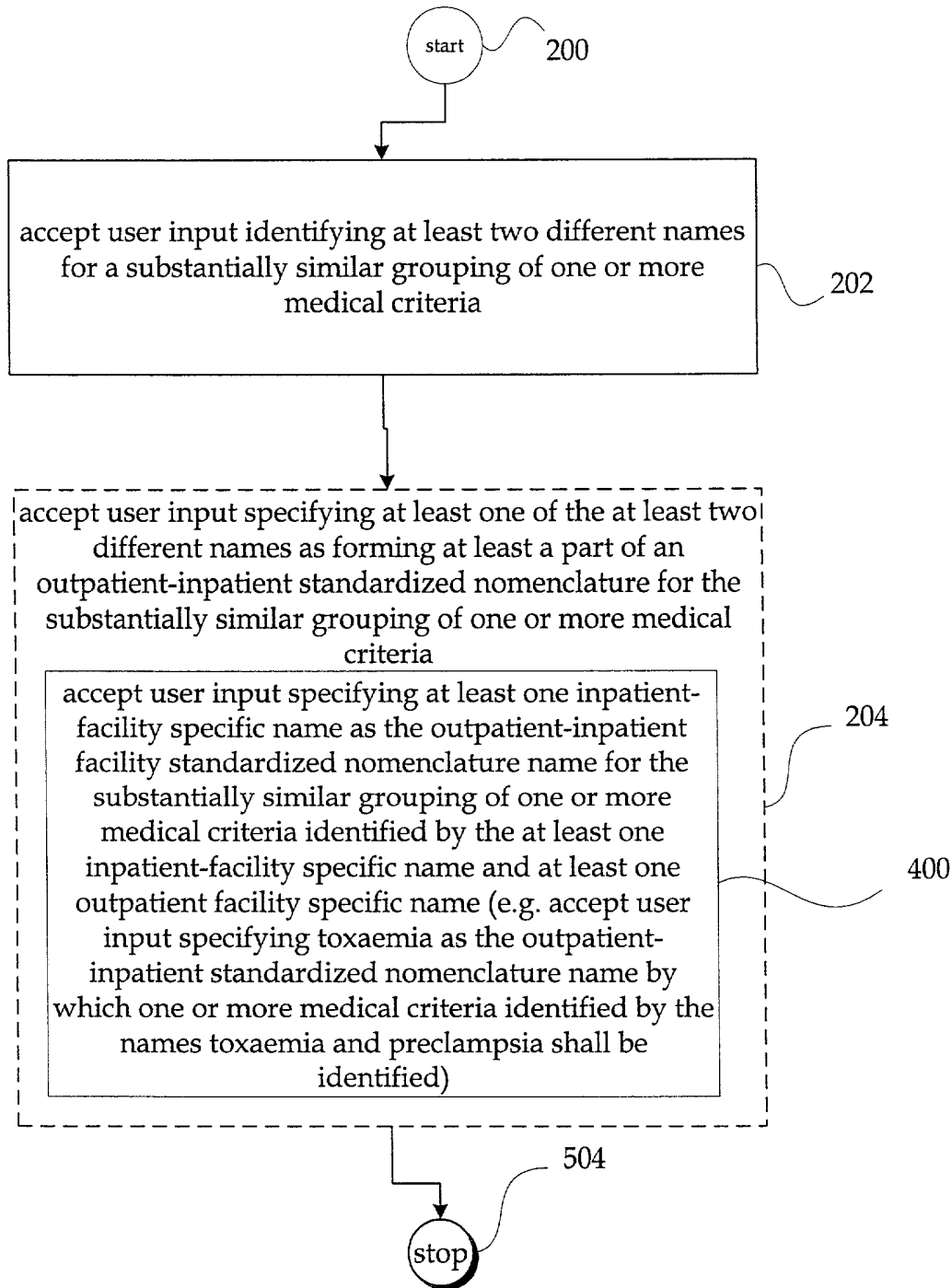


Fig. 4

5/55

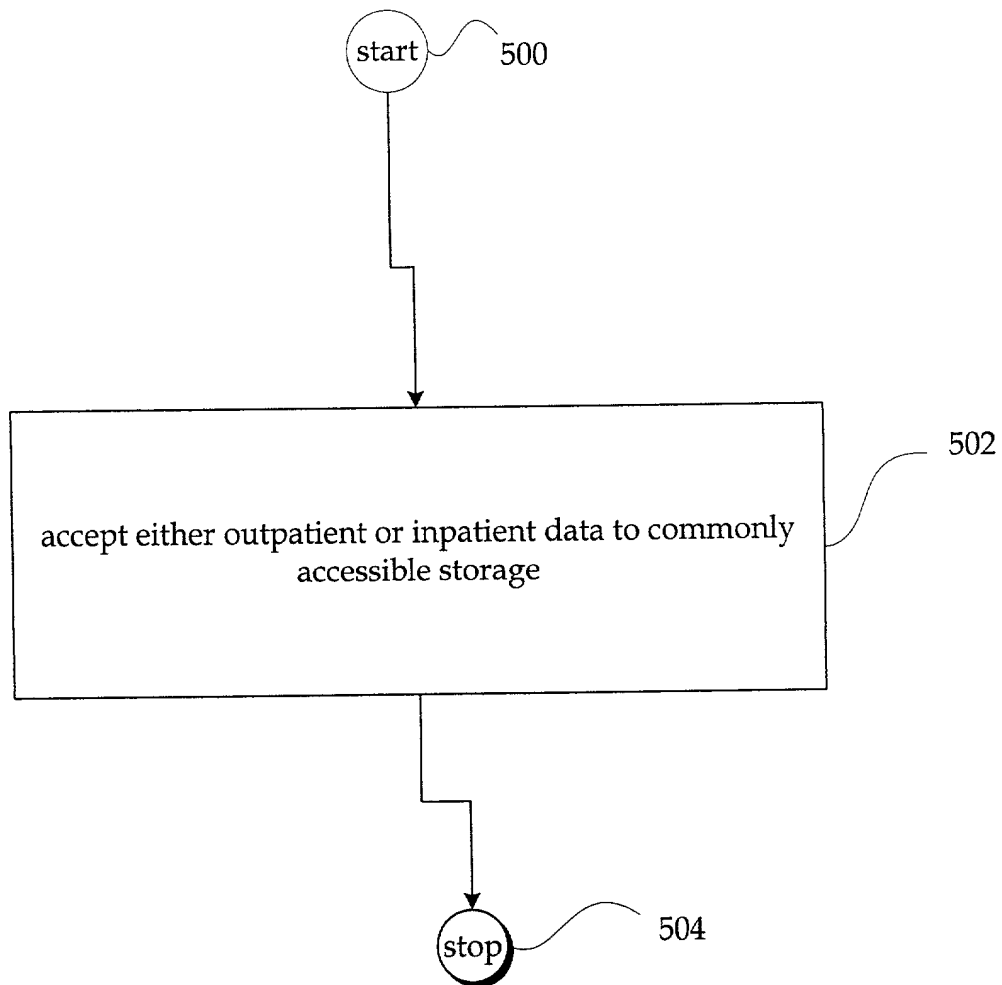


Fig. 5

6/55

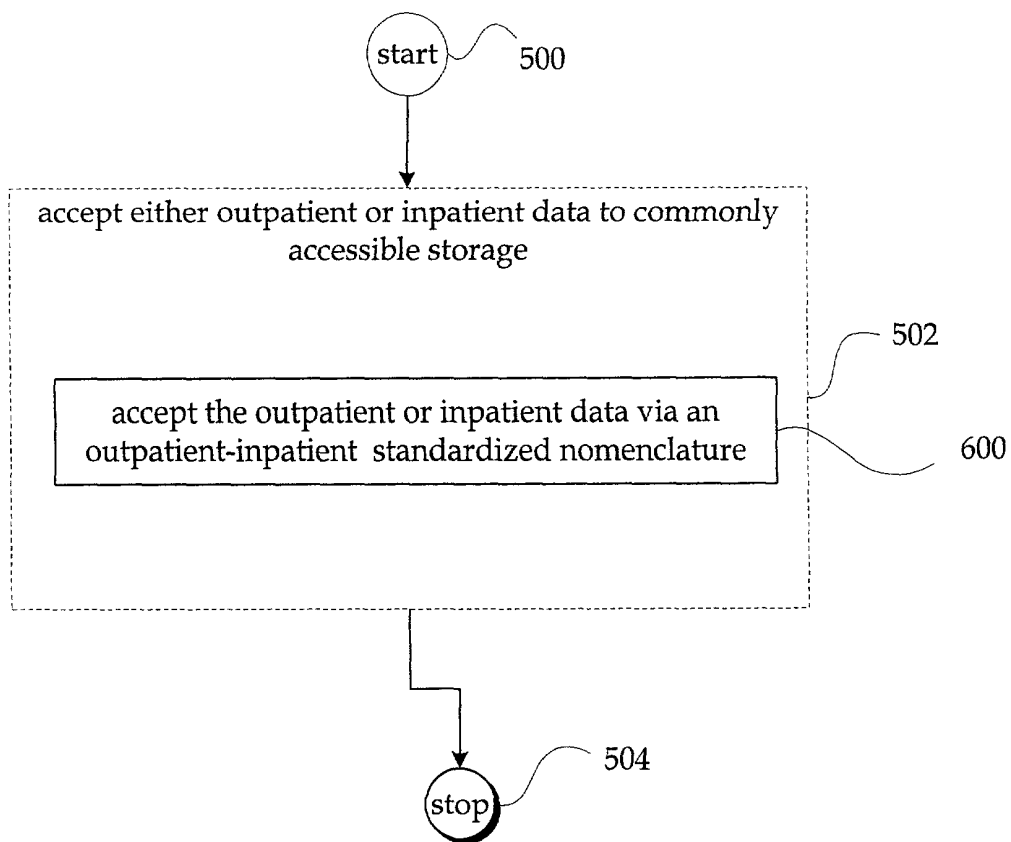


Fig. 6

7/55

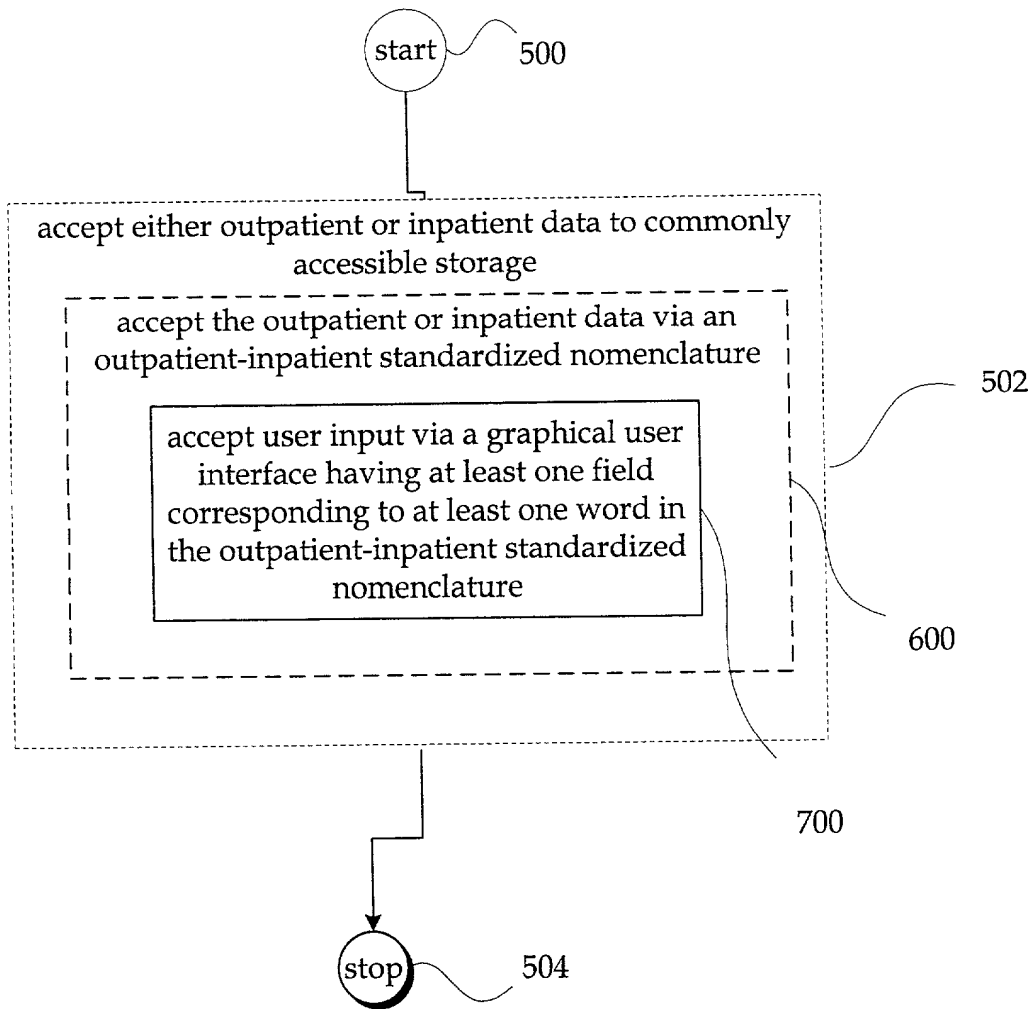


Fig. 7

STORC - Standard Obstetrics Record Charting System ***** TRAINING DATABASE *****

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cerv Exams Demo Tests US Procs Meds Compl Pb List Notes

History for Patient Name; Patient SSN Disposition: DELIVERED

COMPLICATED Age: 38 G/P: 6/1-1-3-2 EDC: 30 Jul 1999 Gest Age: 38 4/7 Type/Rh: A- **STD LABS** **NKDA**

Assoc Visit/Encounter: **ADMISSION** 20 Jul 1999 1610 SF533 History/Physical Data Reviewed By/Date: drmann 21 Jul 1999 1801

PMH/PSH OB Hx Family/Social/Subst Hx Allergies/Menstrual Hx ☐ SF533 is/will NOT be entered in STORC **Next**

☒ Conditions for all other history categories, not listed below, are normal. Note: PMH, PSH and the remarks data will carry over from past pregnancies.

Past Medical Condition(s)	Pb List?	Plan for Pb List	Resolved?	Comment
ASTHMA	<input type="checkbox"/>		<input type="checkbox"/>	since birth, on azthmacort inhaler.
PELVIC INFLAMMATORY DISEASE	<input type="checkbox"/>		<input checked="" type="checkbox"/>	in 1995. Treated successfully with xxx
CONDYLOMA, VAGINAL	<input type="checkbox"/>		<input type="checkbox"/>	
CONDYLOMA, VULVAR				
CONSTIPATION				
CONSTIPATION, CHRONIC				
COPD PULMONALE				
CORONARY ARTERY DISEASE				
CORRECTIVE LENSES				
COSTROCONDITIS				
CROHN DISEASE (REGIONAL ENTERITIS)				
CYSTITIS, SPECIFY				
DEEP VENOUS THROMBOSIS, PRIOR PREGNANC				
DEEP VENOUS THROMBOSSIS, NOT PREG RELAT				

Pb List? Plan for Pb List Comment

Add Surg Delete...

New Remarks: (dbl click for more) Prev Remarks...

☒ Mark SF533 History and Physical Data Reviewed/Save/Close Save/Close Save Cancel Reset Help

Office

Start Slid Inbo CD Inbo CHC CHC FW BE W Micr ST... 2:53 PM

Fig. 7A

9/55

20031123 040302

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Stages of Labor and Delivery for BOND Patient Name; Patient SSN **DELIVERED-CURRENT**

COMPLICATED Age 35 G/P 170-0-0-0 EDC 06 Dec 2001 Gest Age 38 0/7 Type/Rh A+ **STD LABS** **NKDA**

Entered: drcho 23 Nov 2001 1813 **Labor and Delivery Information** Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

General Information

Prior C-Section? ☐ Vaginal Birth Candidate? ☒

First Stage

Onset Date: 23 Nov 2001 Time: 0630

Progress: **AUGMENTED**

Duration: 9hr 8min

Augmentation

☒ Oxytocin Augmentation?

Duration of Oxytocin: 6 hr 20 min

Highest Dose: 9

Enter Other Medications Given During Labor/Delivery:

Analgesia

Analgesia Date (mm/dd/yyyy) Time

FENTANYL 23 Nov 2001

Anesthesia

Anesthesia Date (mm/dd/yyyy) Time

INTRATHECAL ANESTHESIA 23 Nov 2001

EPIDURAL 23 Nov 2001

Induction

Induction Type Date (mm/dd/yyyy) Time

NO INDUCTION 23 Nov 2001

SVD: Op Vag C-Sept

☒ Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Start Stop Print CD Int CH CH PW RE Mic S... 2:21 PM

Fig. 7B

ATTORNEY CLIENT PRIVILEGED AND/OR CONFIDENTIAL

10/55

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Stages of Labor and Delivery for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 D: 7 Type/Rh: A+ STD LABS NKDA

Entered: drcho 23 Nov 2001 1813 **Labor and Delivery Information** Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

Second Stage

Onset Date: 23 Nov 2001 Time: 1538 Duration: 1 hr 12 min

Episiotomy: MIDLINE EPISIOTOMY Date (mm/dd/yyyy): 23 Nov 2001 Add Episiotomy Delete

Laceration: NO LACERATION Date (mm/dd/yyyy): 23 Nov 2001 Add Laceration Delete

Sutures: 2-0 VICRYL SUTURE 2-0 CHROMIC SUTURE

Repair: REPAIR OF LACERATION/EPISIOTOMY IN THE USUAL FASHION

Skin Prep: BETADINE Hospital/Location: LRMC

Newborn Information

Wt(kg) Sex Delivery Type/Outcome Liveborn? Neo Death?

3560 FEM VAGINAL DELIVERY Y N

Third Stage (Placenta)

Onset Date: 23 Nov 2001 Time: 1650

Plac. Deliv: SPONT DELIVERY OF PLACENTA

Deliv. Date: 23 Nov 2001 Time: 1656

Appearance: INTACT & NORMAL

Vessel: 3 VESSELS

Duration: 0 hr 6 min

Summary and Delivery Comment

EBL: 300 ml Dur of Rupture: 12 hr 50 min

Dur Total: 10 hr 26 min

SVD: Op Vag: C-Sept

Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Start Stop Inb CD Inb CH CH Fw RE Mic S... 2:21 PM

Fig. 7C

11/55

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Ph List Notes

Stages of Labor and Delivery for Patient Name: Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A+ **STD LABS** **NKDA**

Entered: drcho 23 Nov 2001 1813 **Labor and Delivery Information** Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

List of Common Delivery Procedures

- AMNIOINFUSION
- ANTIBIOTICS, IV
- FETAL SCALP ELECTRODE
- FOLEY PLACEMENT
- INJECTION, ANTIBIOTICS
- INJECTION, RH IMMUNE GLOBULIN
- IUPC PLACEMENT
- POSTPARTUM TUBAL LIGATION
- REPLACE EPIDURAL
- TRANSFUSION, BLOOD EXPANDERS
- TRANSFUSION, FRESH FROZEN PLASMA
- TRANSFUSION, PACKED RED BLOOD CELLS
- TRANSFUSION, PLATELETS

Current List of Other Procedures for Selected Patient

Procedure	Date	Time	Perfc
FETAL SCALP ELECTRODE	23 Nov 2001	1350	
FOLEY PLACEMENT	23 Nov 2001	1410	

Add Selected Procedure for Patient Refresh List Enter Additional Procedures

SVD: Op Vag C Sect

Office

Start End Inb CD Inb CH CH FW RE Mic 2:22 PM

Fig. 7D

12/55

STORC - STandard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Ph List Notes

Stages of Labor and Delivery for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 39 0/7 Type/Rh: A+ STD LABS NKDA

Entered: drcho 23 Nov 2001 1813 Labor and Delivery Information Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

List of Common Delivery Complications

- BLADDER INJURY
- BOWEL INJURY
- CARDIOPULMONARY ARREST, NOT RESUSCITATED
- CARDIOPULMONARY ARREST, RESUSCITATED
- EXTRAUTERINE PREGNANCY (EUP)
- HEMATOMA, VAGINAL
- HEMATOMA, VULVAR/PERINEAL
- HEMORRHAGE
- INDUCTION OF LABOR, FAILED - SPECIFY
- INDUCTION OF LABOR, MECHANICAL - FAILED
- MATERNAL MORTALITY
- MULTIPLE GESTATION WITH MALPRESENTATION
- MULTIPLE GESTATION, LOSS OF ONE OR MORE

Add Selected Complication for Patient

Current List of Other Delivery Complications for Selected Patient

Delivery Complication for Mother	Comment

Refresh List Enter Additional Complications...

SVD: Op/Vag: C Sect

Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Start Sld... Inb... ED... Inb... CH... CH... RW... RE... Mic... S... 2:22 PM

Fig. 7E

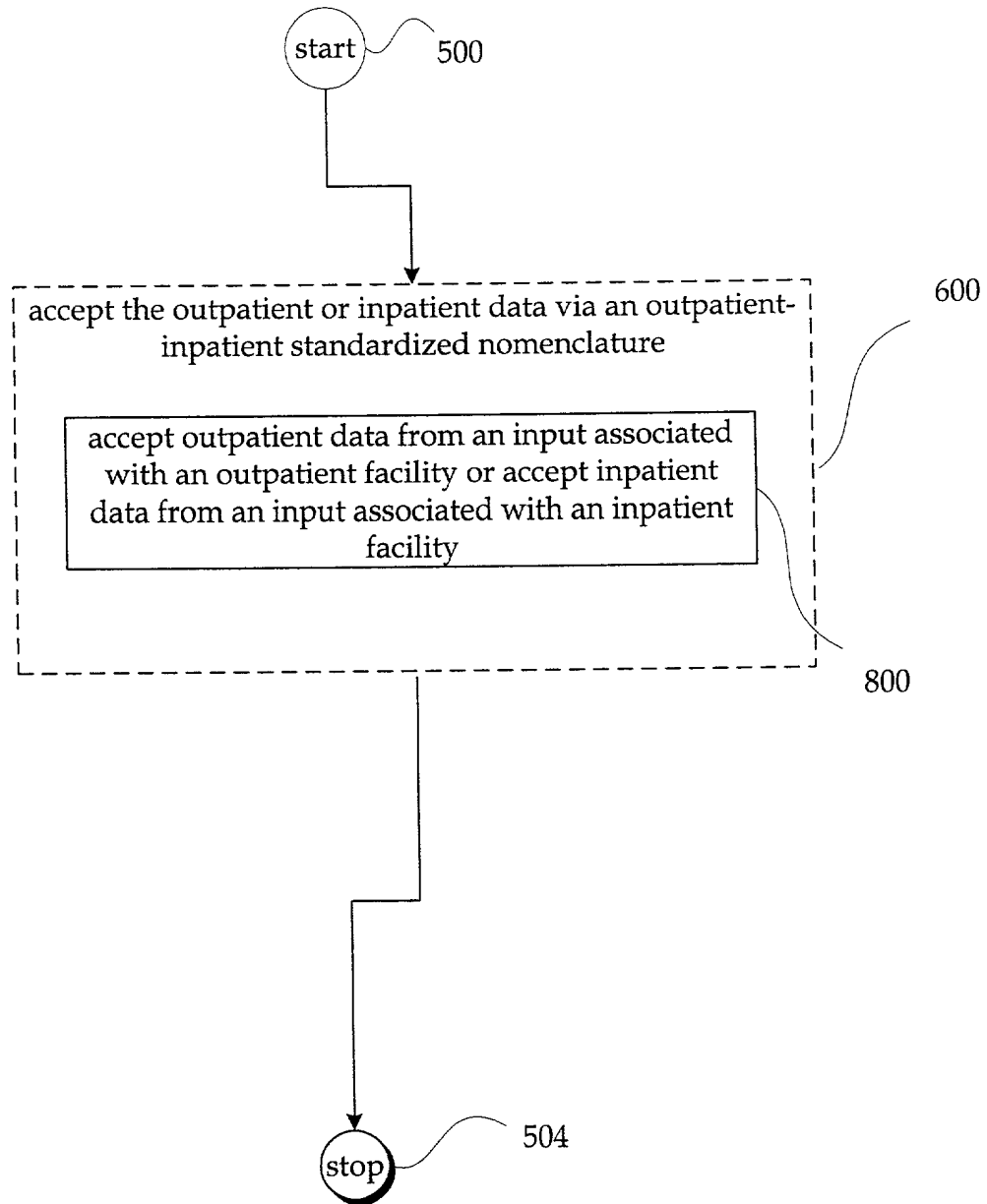


Fig. 8

14/55

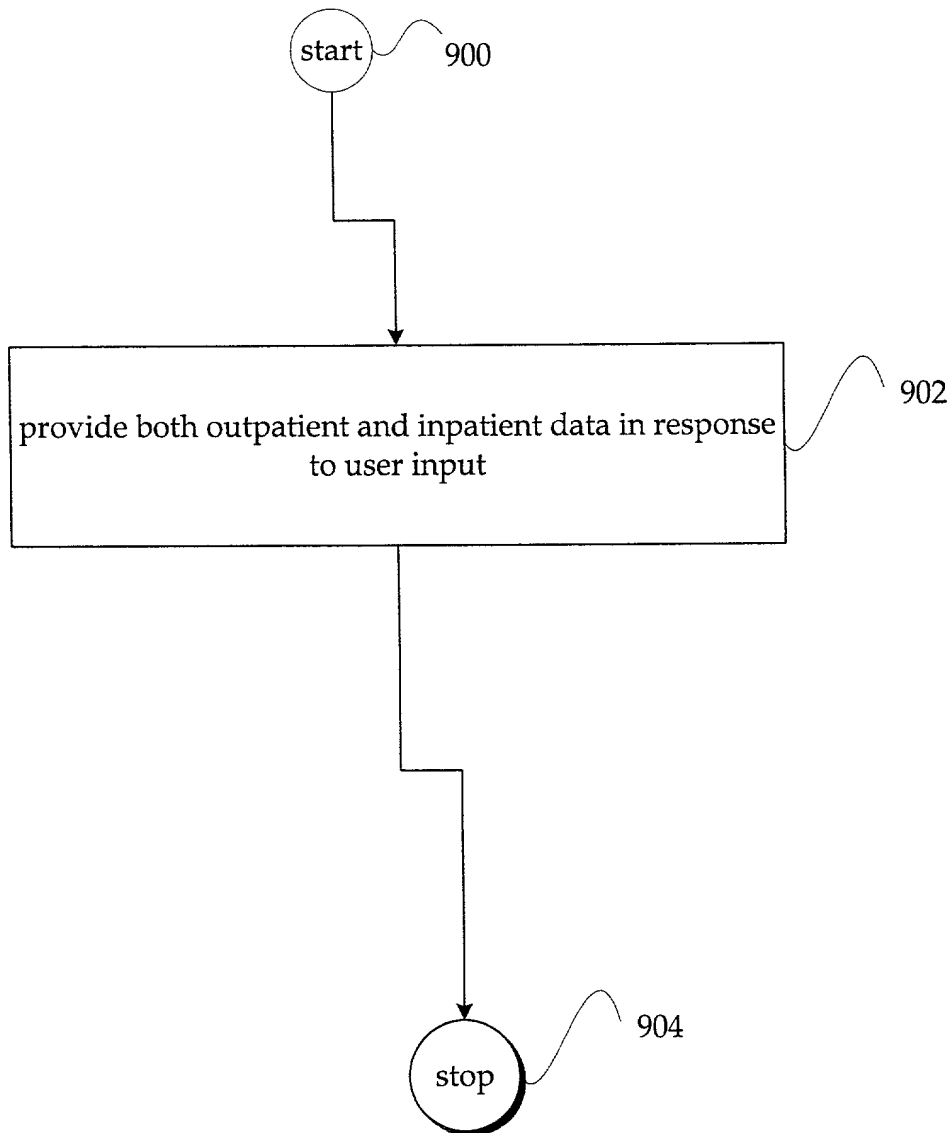


Fig. 9

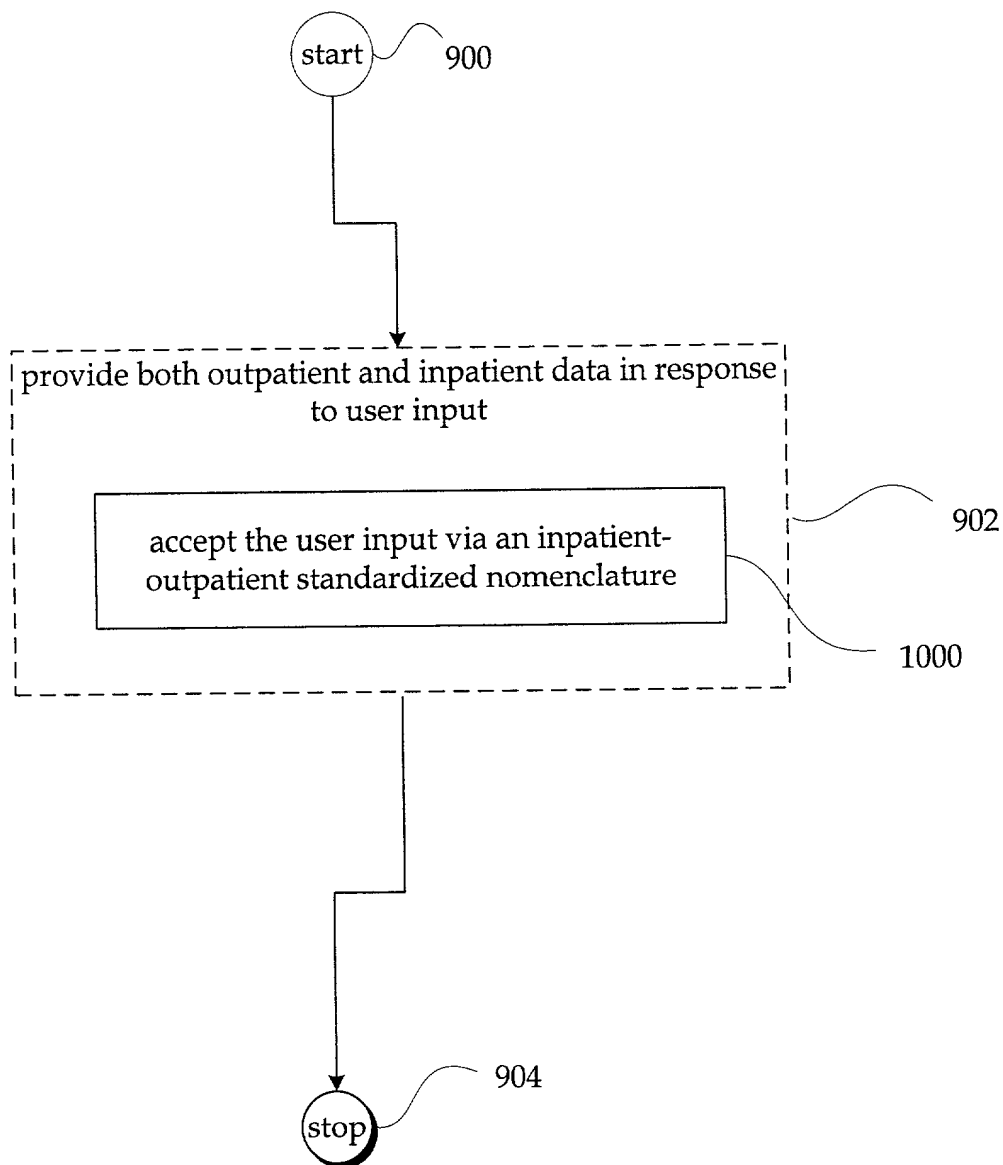


Fig. 10

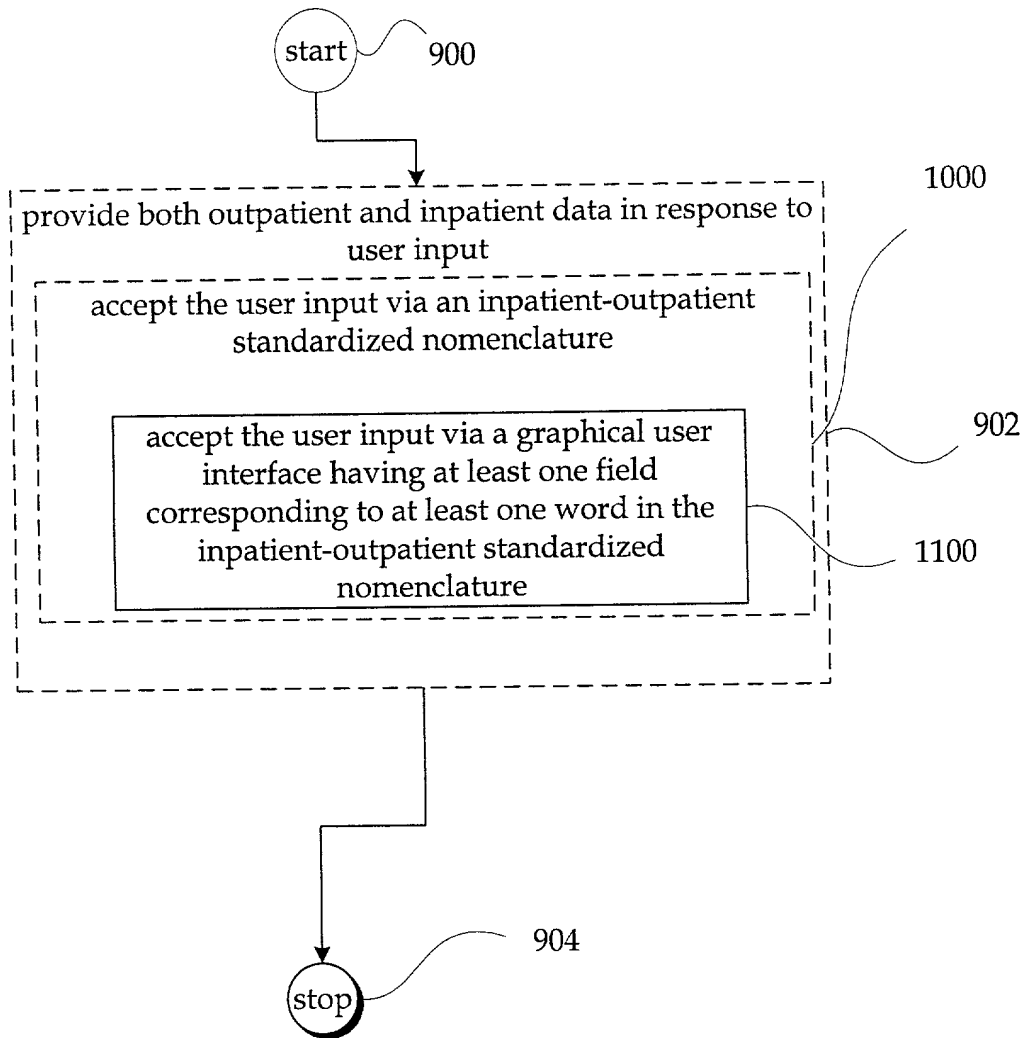
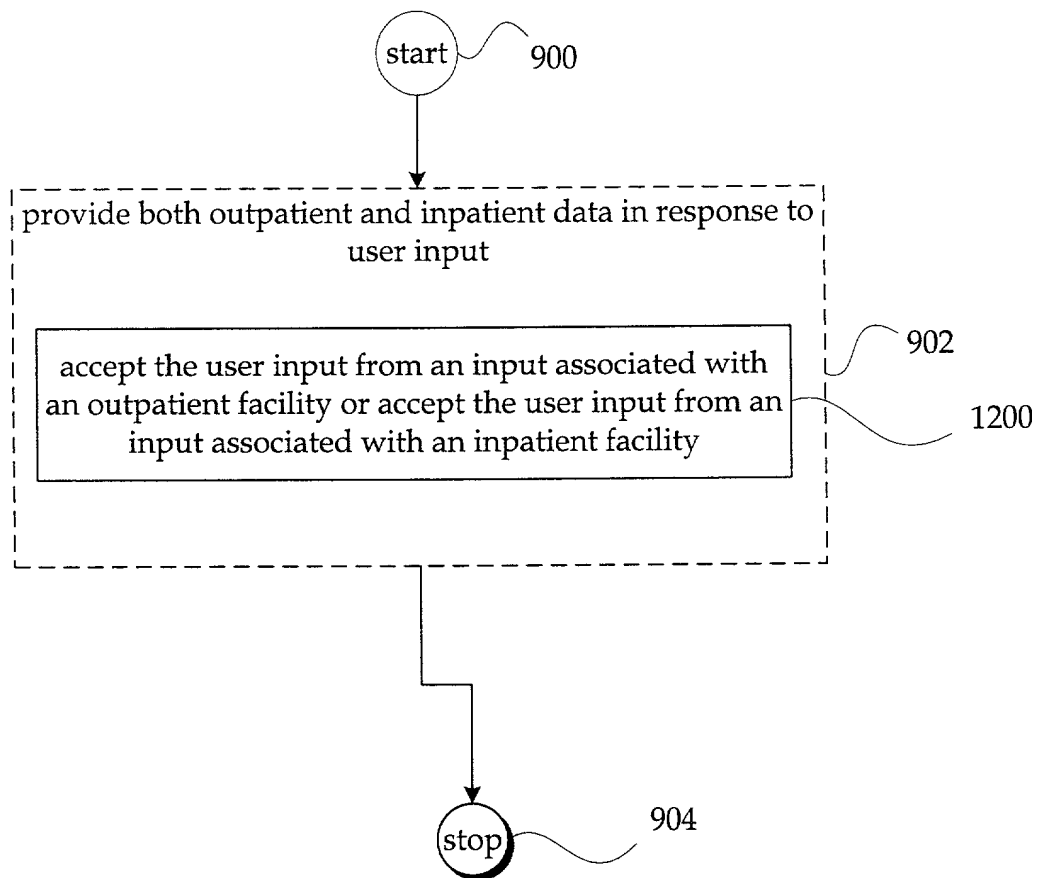


Fig. 11

*Fig. 12*

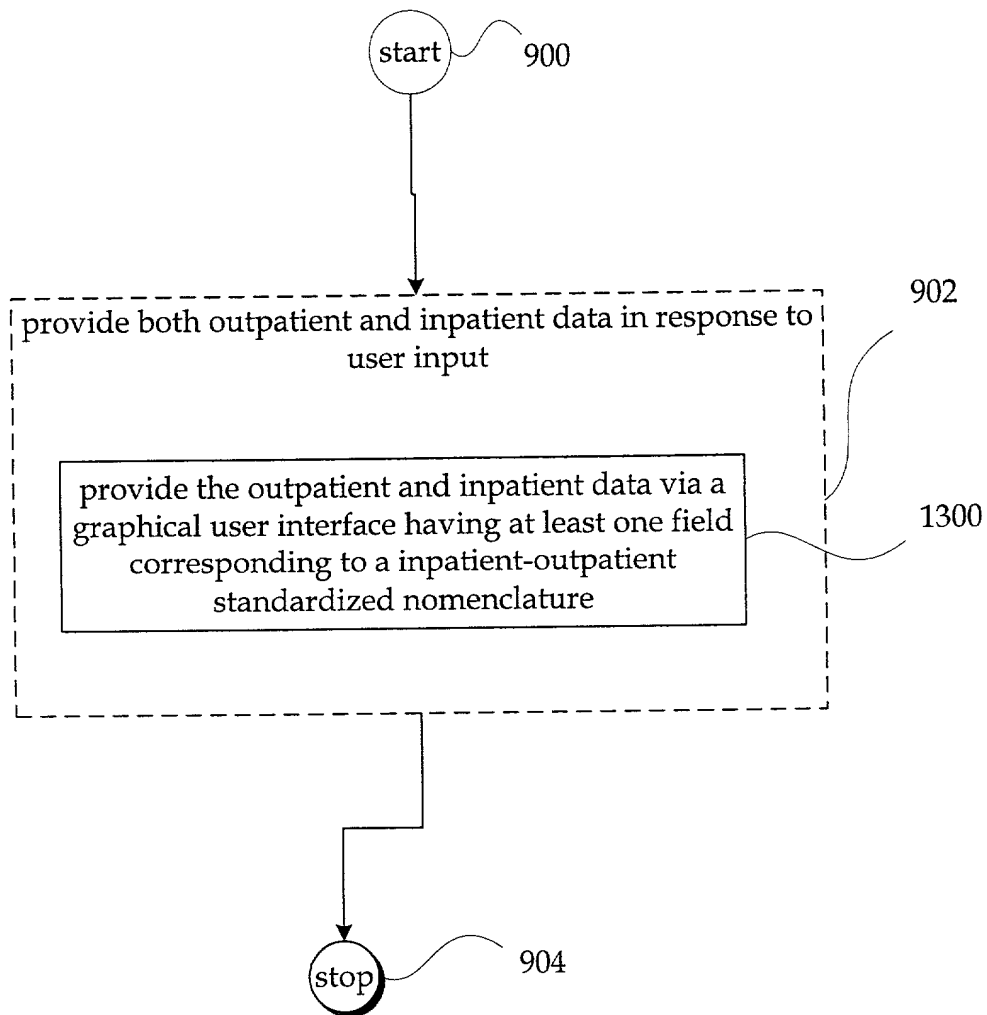


Fig. 13

19/55

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cerv Exams Demo Tests US Procs Meds Compl Pb List Notes

Key Information for Patient Name; Patient SSN Disposition: PREGNANT

UNASSIGNED Age: 26 G/P: 3/0/0/2/0 EDC: 16 Dec 2001 Gest Age: 38 Wk 7 Type/Rh: O- STD LABS ALLERGIES

Notes Labs Phone Consult Print **Key Information** All Pbs Major Minor Row Height: 100

Problem List (R = Resolved)

R	Problem/Condition	Plan (Double click in field to see entire plan)	Comment	Date
	ASTHMA	on Alupent/Azthmacort inhaler prn		02 C
	LATEX ALLERGY	delivery at LRMC	associated with RASH	02 C
	OTHER, SPECIFY		Pt reports allergy to PCN, Tetracycline, Sulfa,	25 C
	OVARIAN MASS CYSTIC, SPECIFY	L - 9 cm simple cystic mass- transfer from	delivery at LRMC	02 C
	RH NEGATIVE			25 C
	SEIZURE DISORDER, OTHER	Not active	CHILDHOOD ILLNESS	02 C

Allergies

Allergy Name	Comment
CLINDAMYCIN	swelling
LATEX	

Surgical History

Surgical Procedure	Comment

Current/Prior Admissions

Current Meds (not available yet)

Social/Substance History

Social/Substance Condition	Comment

Note: If some items are not listed and they should be, make sure you have saved all changes on all open screens and then click Refresh. Use the Windows menu option to view a list of open screens.

Close Refresh Help

Office

Microsoft

Start Slide Sh CHSC CHS Inbox STORC RE Let Microso...

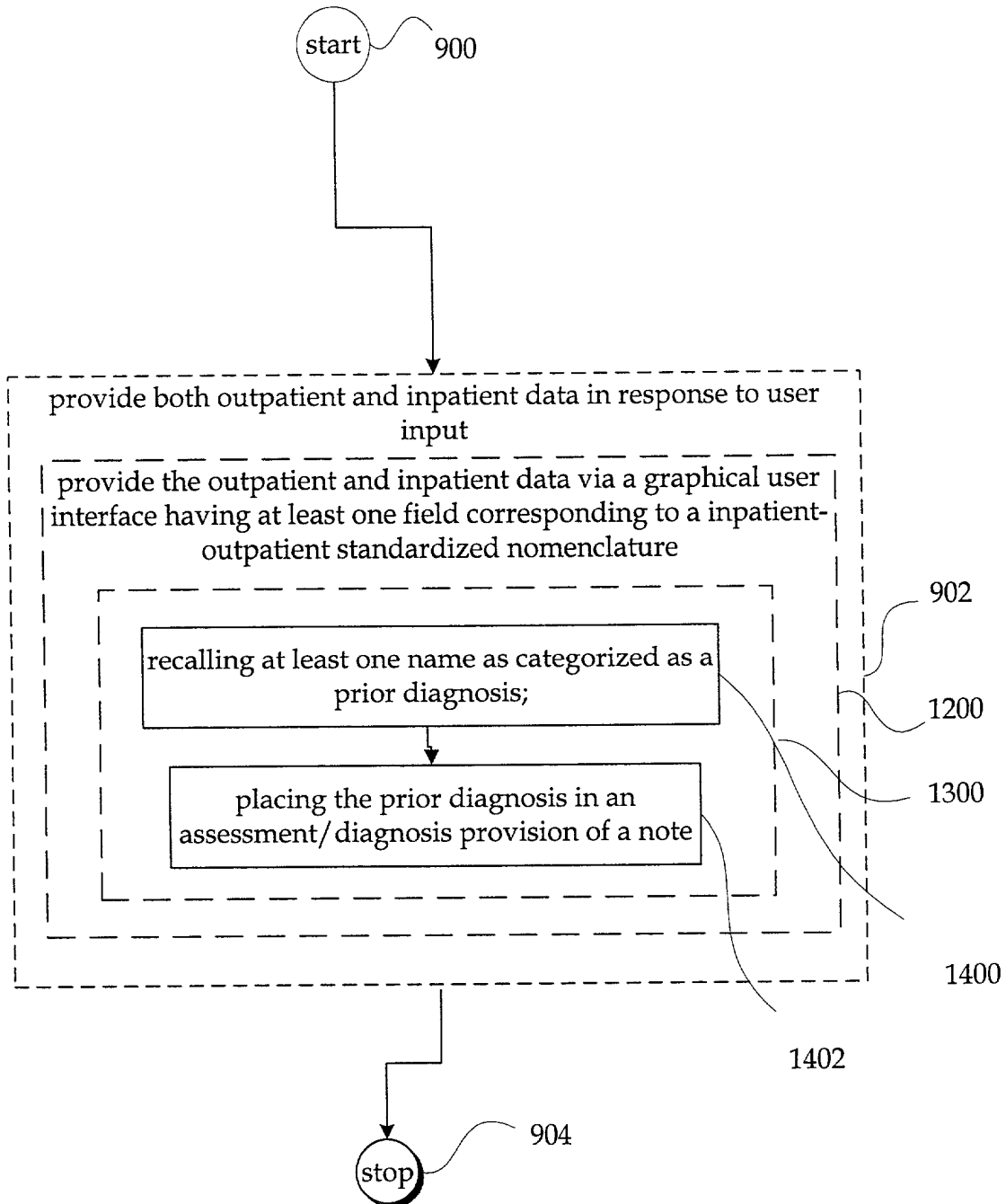
6:35 AM

1352

1354

1350

Fig. 13A

*Fig. 14*

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cerv Exams Demo Tests US Procs Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name; Patient SSN Disposition: DELIVERED

COMPLICATED Age: 38 G/P: 6/1-1-3-2 EDC: 30 Jul 1999 Gest Age: 38 4/7 Type/Rh: A- STD LABS NKDA

Detailed OB Visit Information

Subjective Objective Assessment/Plan

Assessment

Assessment (Health Condition/Diagnosis)	Pb List?	Plan (DB Click)	R/O?	Comment
LATEX ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ROB, UNCOMPLICATED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient-Specific Assessment(s)

Plans

Standard Plan/Remark	Entered By	Entered Date	Del
Standard Plan for >= 41 wks	drmann	30 Nov 2001 1500	

Patient-Specific Plan(s)

Labor Precautions, Daily Fetal Kick Counts recommended, RTC in 1 week, NST/AFI 2x/wk, Consider induction

CHRONIC CONDITIONS WERE ADDED View Existing Notes OK Cancel Reset Help

Office

Start Slide... Inbo... CD... Inbo... CHC... CHC... FW... RE... Microsoft Word - Document5 12:46 PM

Fig. 14A

22/55

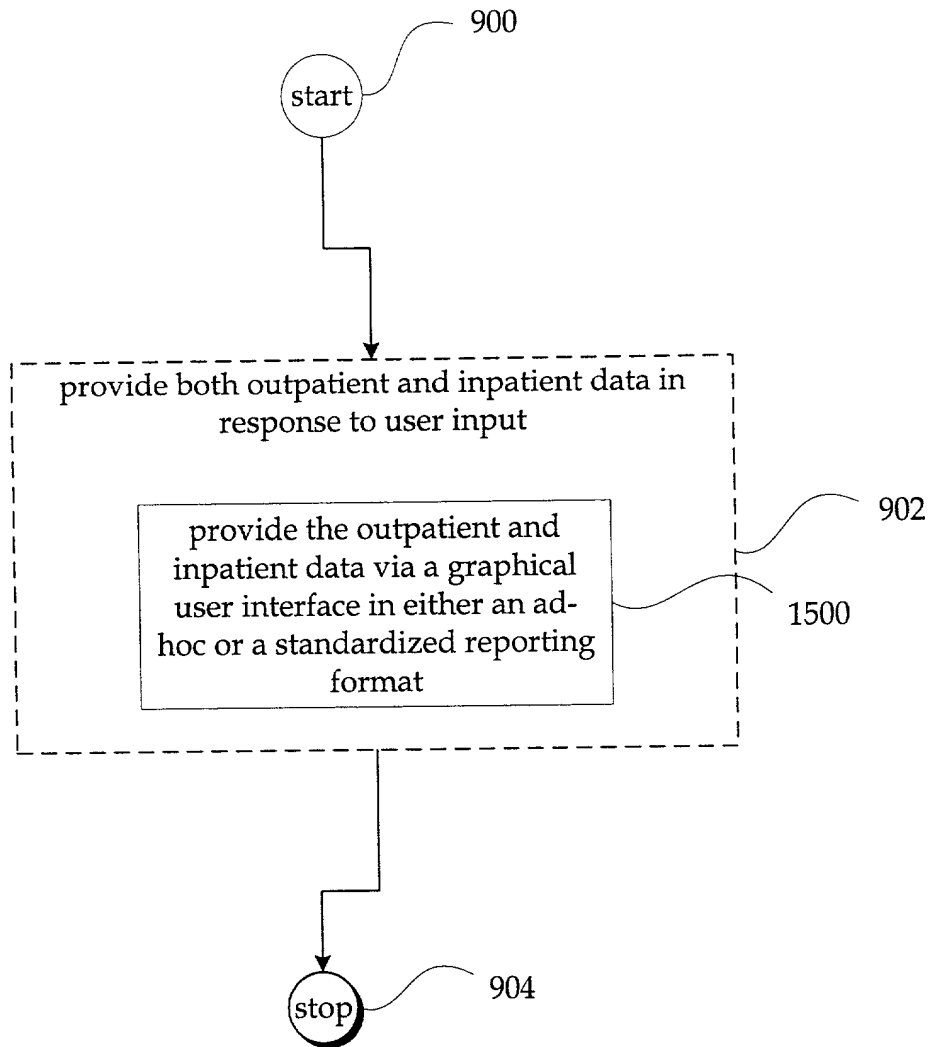
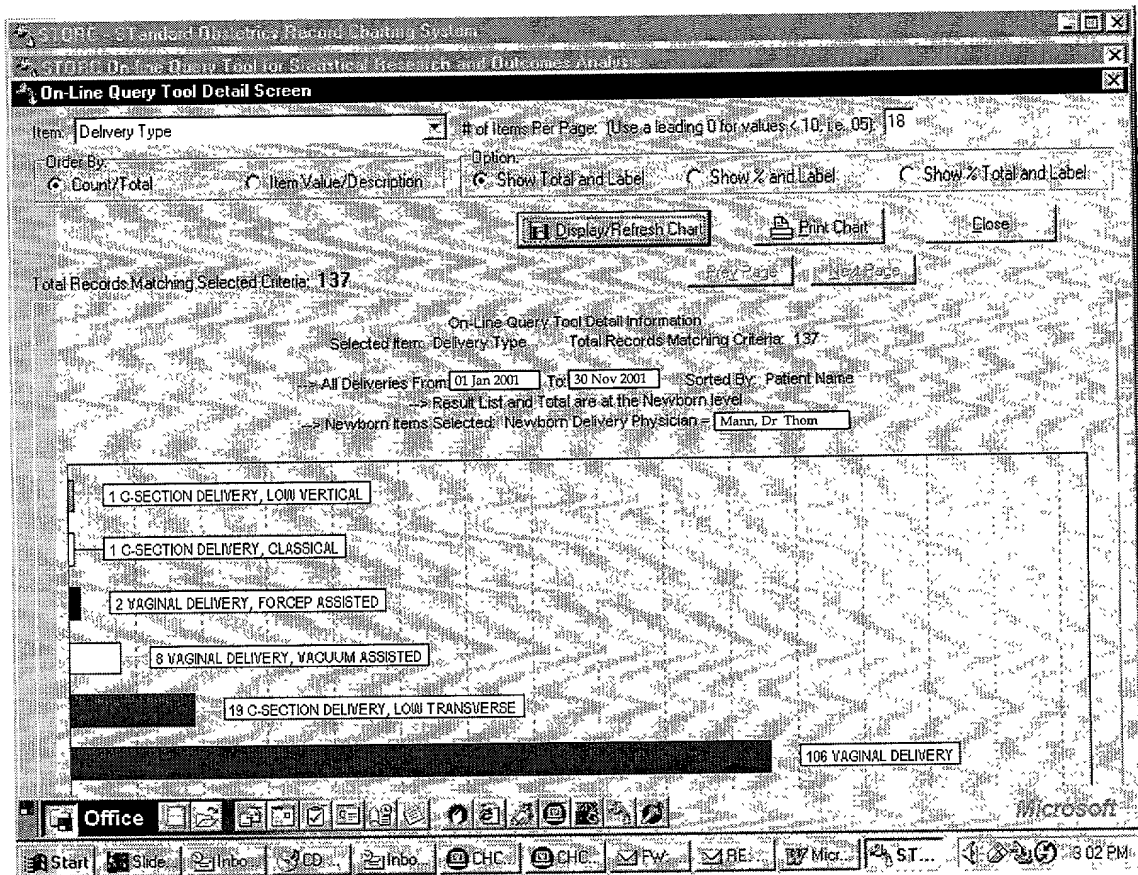


Fig. 15



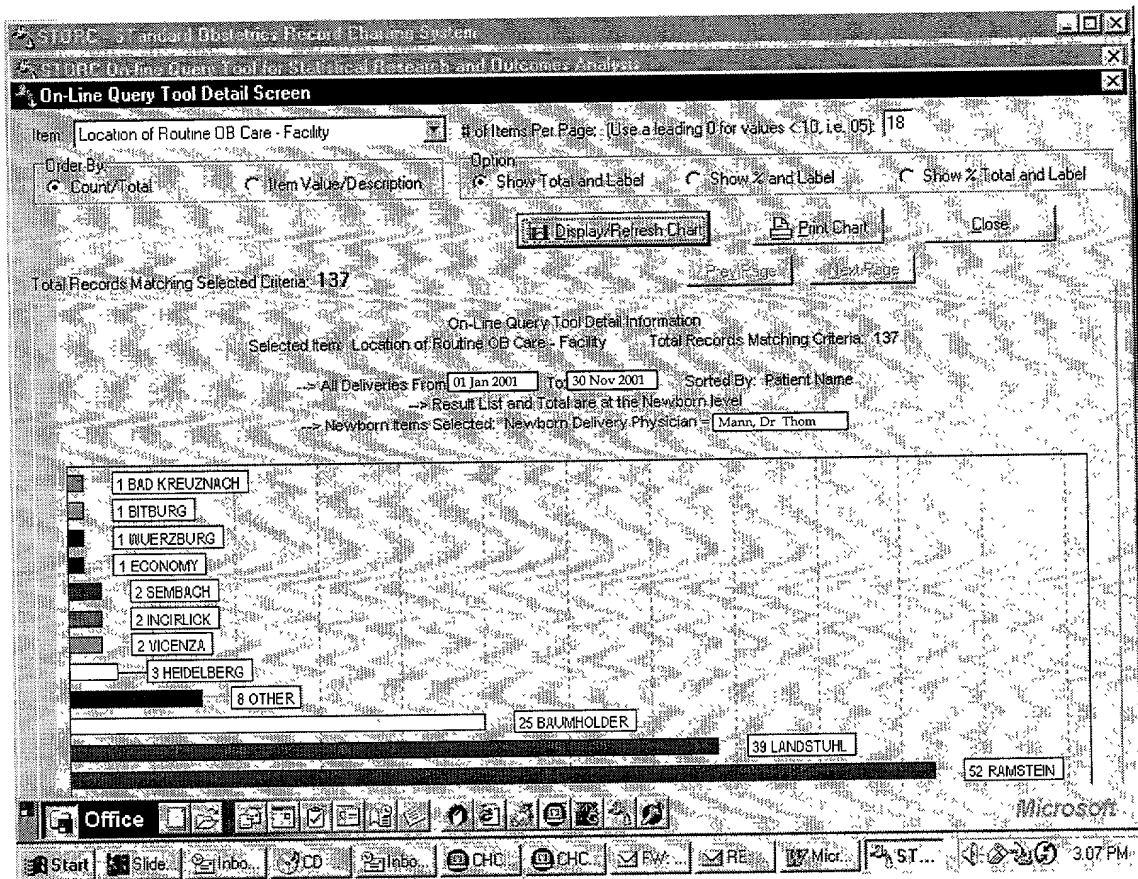
1552

1550

Fig. 15A



1570



1580

1582

Fig. 15C

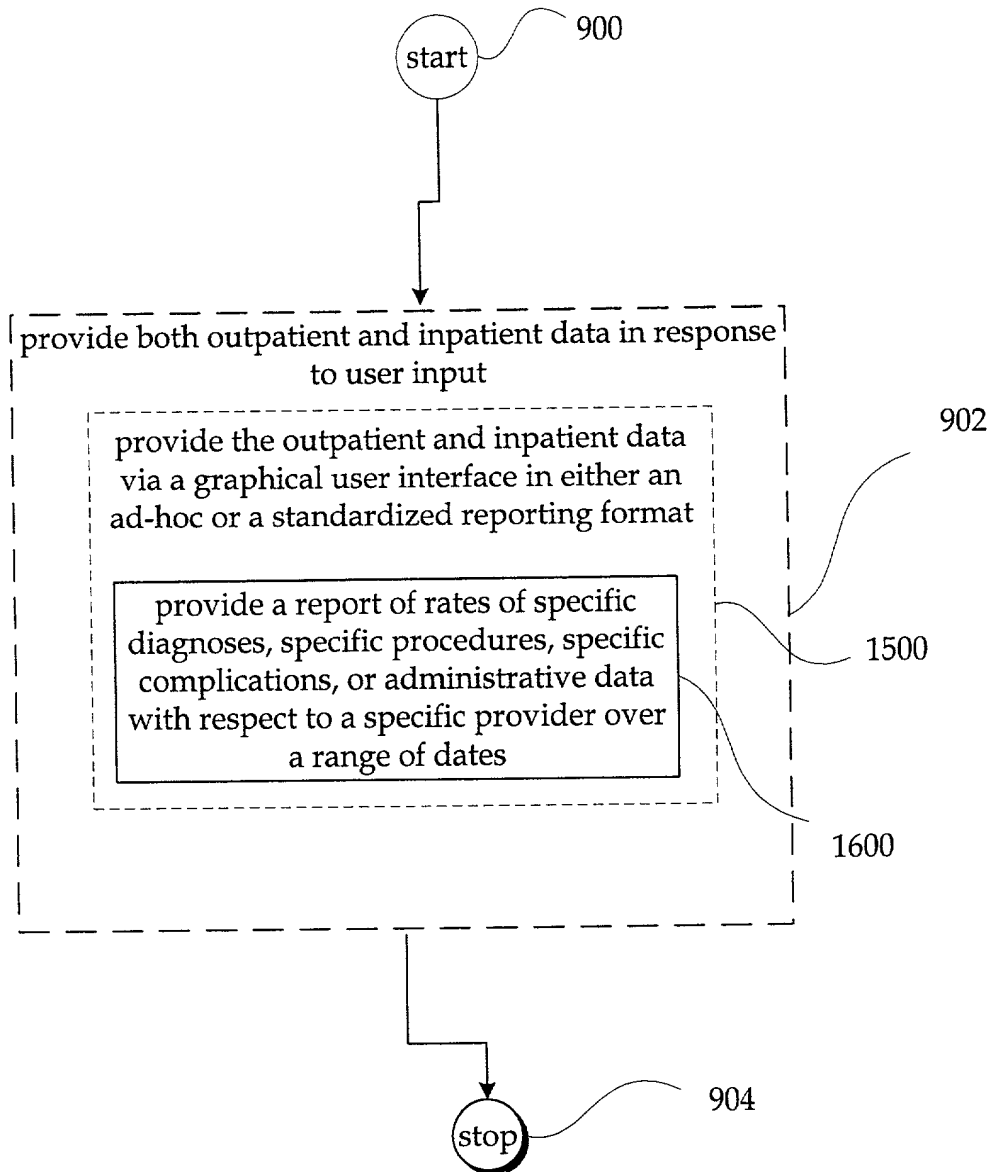


Fig. 16

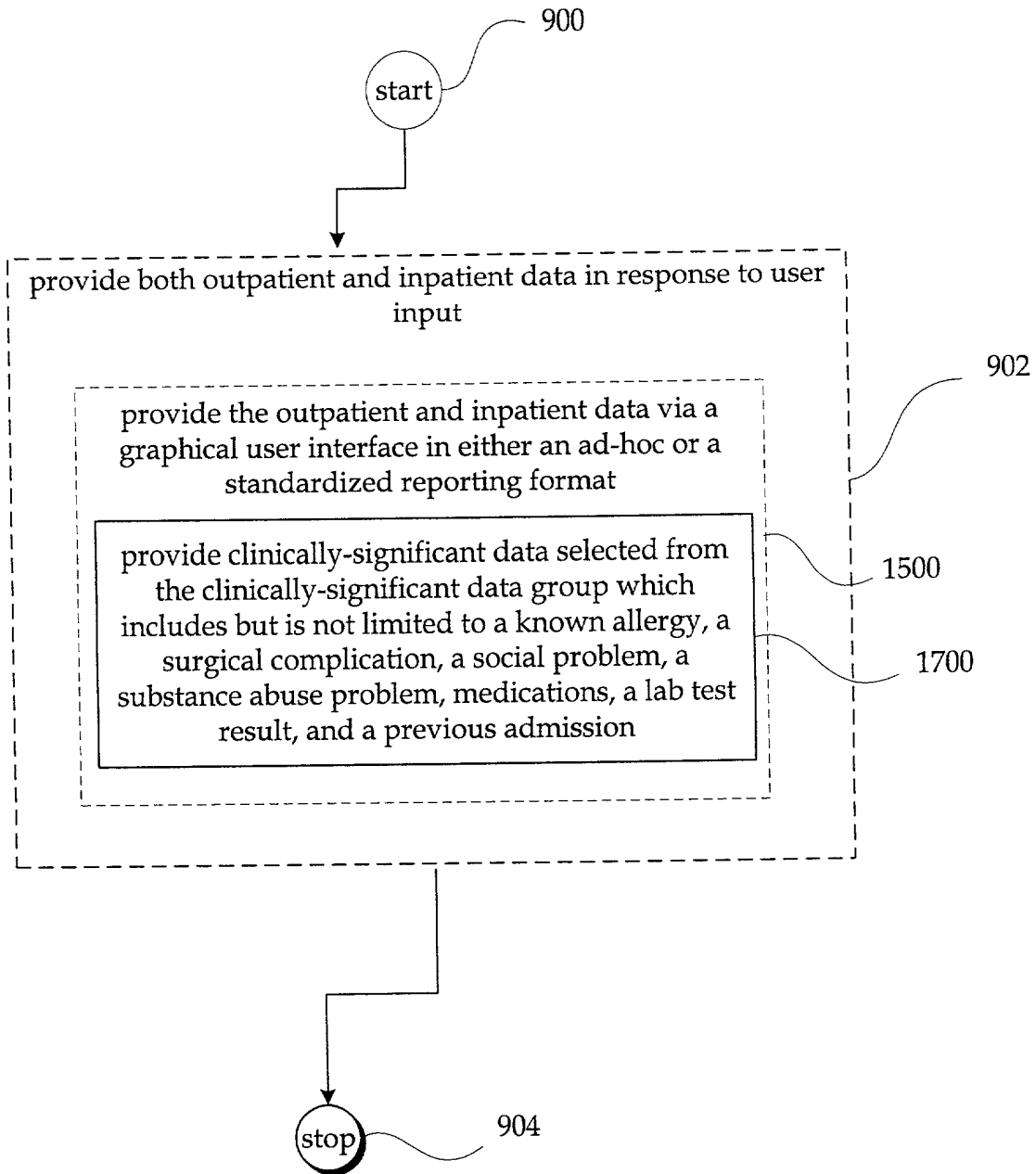


Fig. 17

28/55

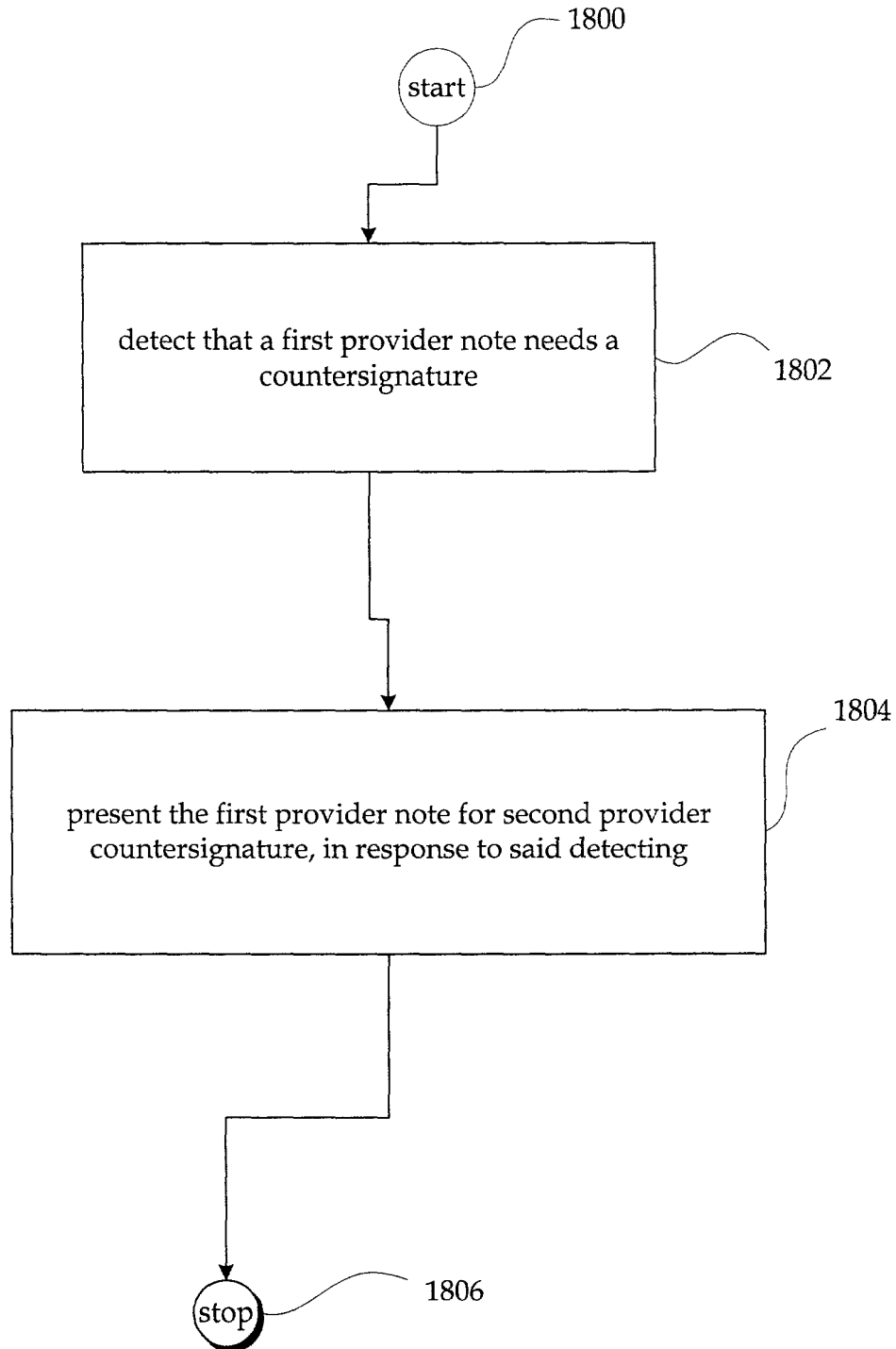
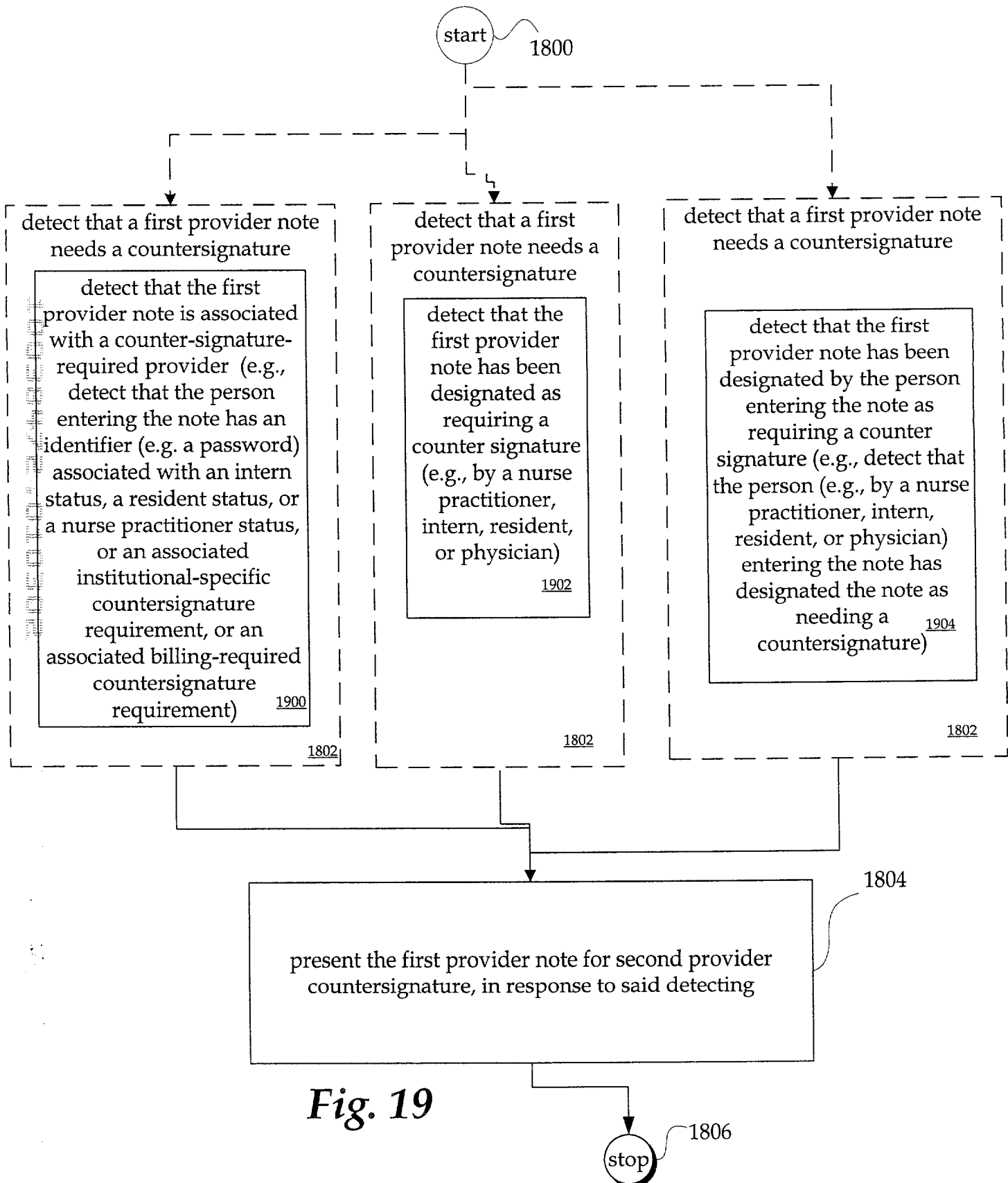


Fig. 18

**Fig. 19**

30/55

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Labor and Delivery

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Progress Notes for Patient Name; Patient SSN Disposition: PREGNANT

UNASSIGNED Age 32 G/P 1/0-0-0-0 EDC 30 Feb 2002 Gest Age 26 W 7 Type/Rh A+ STD LABS ALLERGIES

Assoc Visit/Encounter ROUTINE OB View Existing Notes

New Phone Call/Consult 17 Nov 2001 0800

Progress Note Category ANTEPARTUM NOTE Provider to Review Note Doe, John A. Date the Note is for (optional)

Standard Note Free Text/Addendum to Standard

Blank/Addendum Text

Test note

Time

Critical?

Yes No

Type

Inpatient Outpatient

Next

View Entire Note... Save/Close Save Cancel Reset Help

Office

Start Slide Inbo CD Inbo CHC CHC FW RE Micr ST 3:34 PM

1950

1952

Fig. 19A

31/55

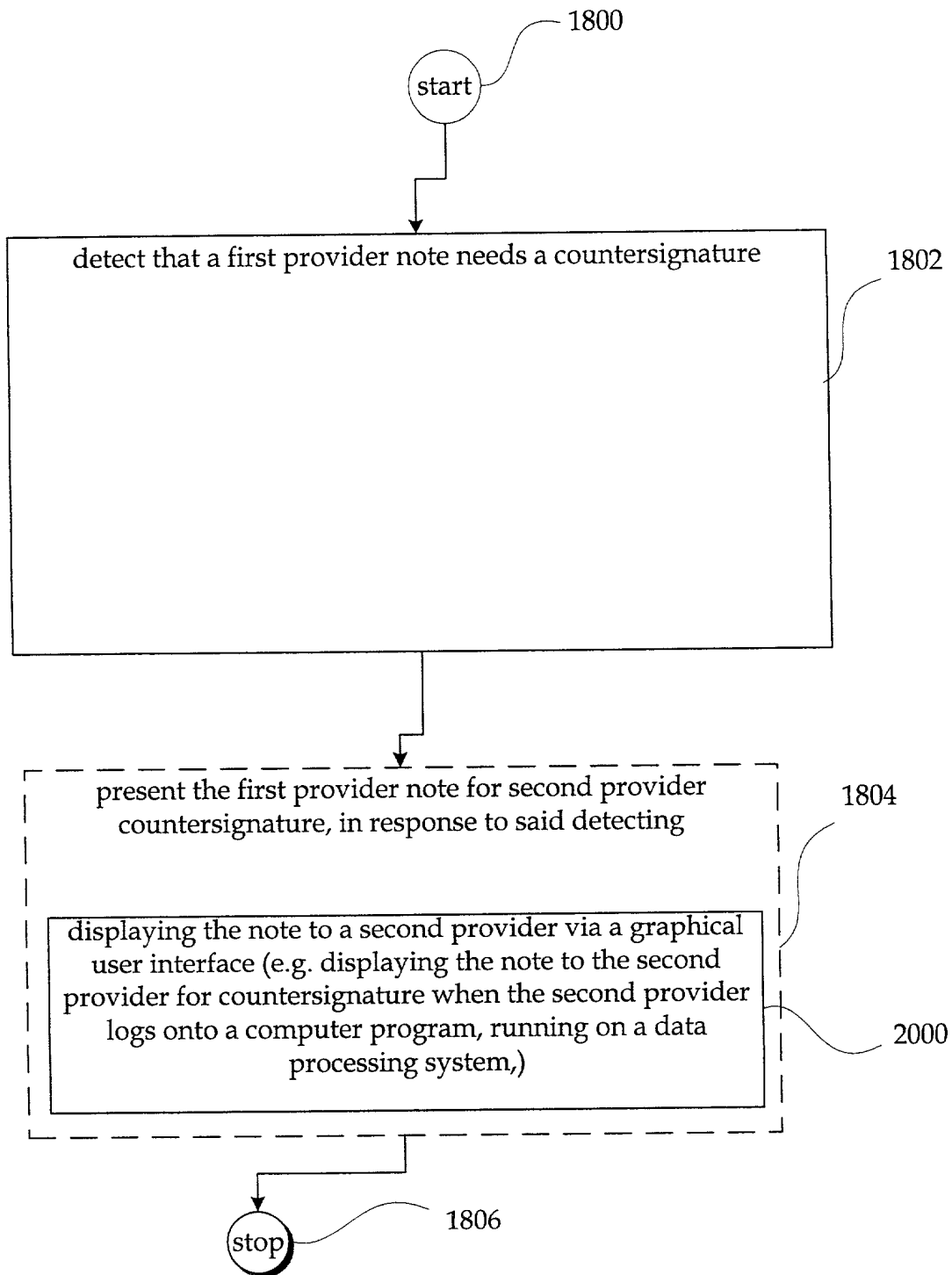
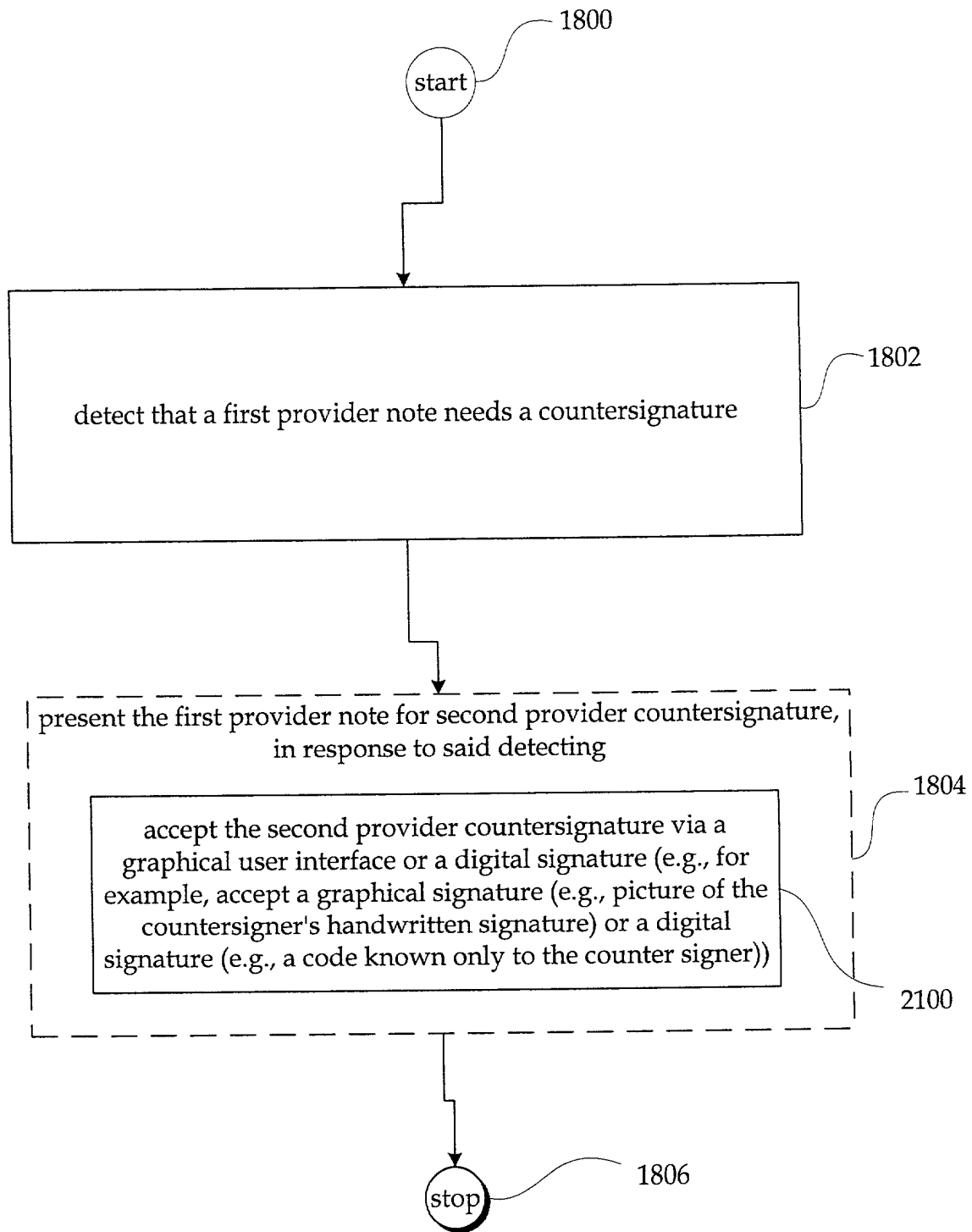


Fig. 20



ATTORNEY CLIENT PRIVILEGED AND/OR CONFIDENTIAL

*Fig. 21*

34/55

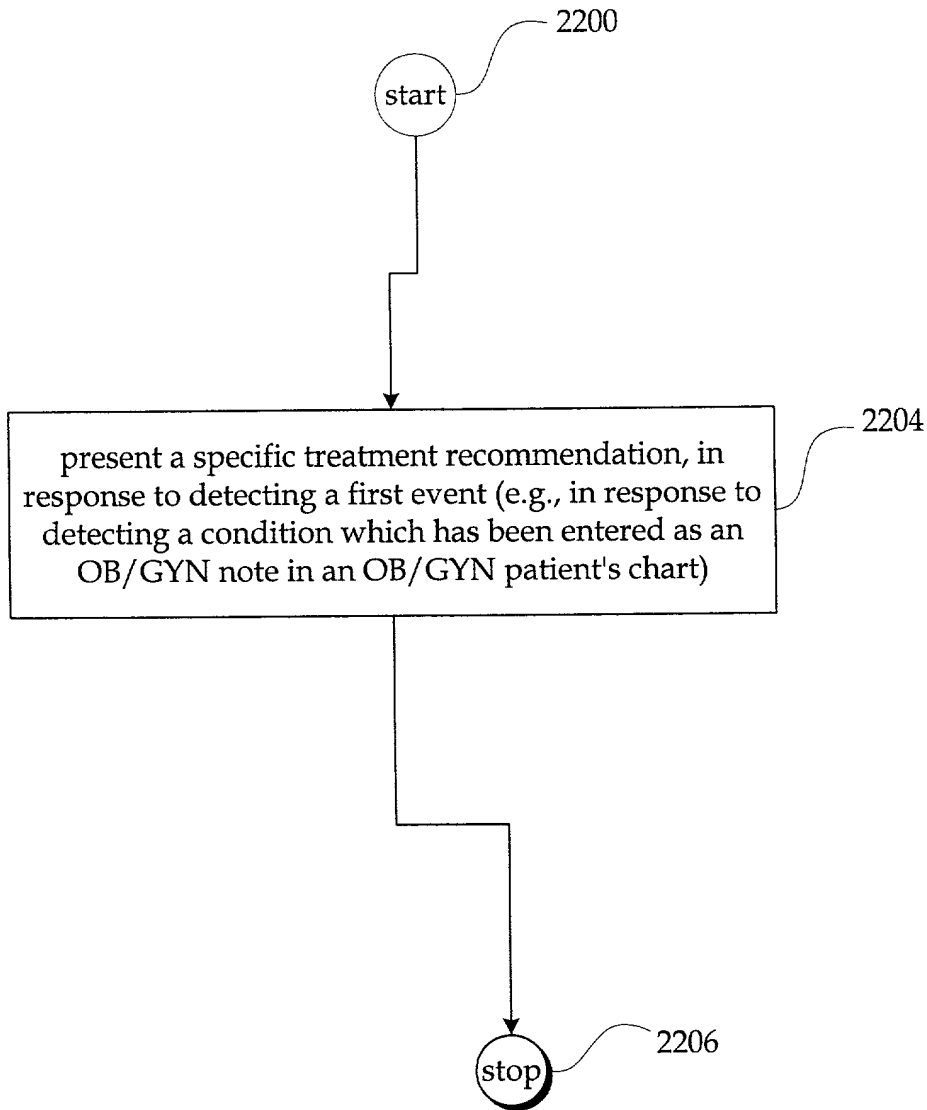


Fig. 22

STORC: Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Labor and Delivery

Key Info General Visits Adm History Exams Delivery Discharge Demo Tests US Procs Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name; Patient SSN Disposition: PREGNANT

LOW Age: 20 G/P: 2/0-0-1-0 EDC: 08 Mar 2002 Gest Age: 17 1/7 Type/Rht: 0+ STD LABS NKDA

Detailed OB Visit Information

ROB Visit COB Visit Next

Subjective Objective Assessment/Plan

Assessment

Assessment (Health Condition/Diagnosis)	Pb List	Plan (Dbl Click)	R/O	Comment
OBESITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ROB, UNCOMPLICATED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MASTITIS, PREGNANCY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Assessment (Health Condition/Diagnosis) Pb List Plan (Dbl Click) R/O Comment Add Delete ROB COB

Patient-Specific Assessment(s):

Plans

Standard Plan/Remark	Entered By	Entered Date	Del
Standard Plan for 15 - 19 wks	drmann	17 Nov 2001 1408	

Standard Plan/Remark Entered By Entered Date Del Add Plan Delete Sid

Patient-Specific Plan(s):

Offered Triple Screen, RTC in 4-6 weeks, Note quickening
RX with Dicloxacillin.

View Existing Notes OK Cancel Reset Help

Office

Start Slid Inbo CD Inbo DHC DHC FW RE Micr ST 3:26 PM

2254

2256

2250

Fig. 22A

36/55

2252

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: OB/Clinic

Key Info General Visits Physical History Cerv Exams Demo Tests US Procs Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name; Patient SSN/ Disposition: PREGNANT

UNASSIGNED Age: 37 G/P: 3/1-0-1-1 EDD: 08 Mar 2001 Gest Age: 31 5/7 Type/Rh: B+ STD LABS NKDA

Detailed OB Visit Information

ROB Visit COB Visit Next

Subjective Objective Assessment/Plan

Assessment

Assessment (Health Condition/Diagnosis)	Pb List?	Plan (Click)	R/O?	Comment
ADVANCED MATERNAL AGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ROB, UNCOMPLICATED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

ADD Delete... ROB COB

Patient-Specific Assessment(s)

Plans

Standard Plan/Remark	Entered By	Entered Date	Del
Standard Plan for > 28 wks and < 36 wks	drmann	24 Nov 2001 1103	

ADD Plan Delete... Std

Patient-Specific Plan(s)

Preterm Labor Precautions, RTC in 2 weeks.
Daily Fetal Kick Counts recommended, Breast
feeding class encouraged, Signs/symptoms of
preeclampsia reviewed, Preadmit if not yet done

View Existing Notes OK Cancel Reset Help

Office

Stan Slide Inbo... CD Inbo... CHC... CHC... PW... RE... Mic... ST... 3:12 PM

2254

2250

2256

Fig. 22B

37/55

2252

STDRS Standard Obstetric Record Charting System

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cerv Exams Demo Tests US Procs Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name; Patient SSN Disposition: ADMITTED

COMPLICATED Age: 22 G/P: 170-00-0 EDC: 19 Mar 2001 Gest Age: 41 4/7 Type/Rbz: A STD LABS ALLERGIES: [X]

Detailed OB Visit Information

Subjective Objective Assessment/Plan

Assessment

Assessment (Health Condition/Diagnosis)	Pb List?	Plan (Dbl Click)	R/O?	Comment	Add	Delete
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recommended right arm and right leg B/Ps each visit		
CARDIAC DISEASE, SPECIFY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
RH NEGATIVE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
ROB, UNCOMPLICATED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

ROB COB

Patient-Specific Assessment(s):

Plans

Standard Plan/Remark	Entered By	Entered Date	Del	Add Plan	Delete	Std
Standard Plan for >= 41 wks	drmann	27 Nov 2001 1012				

Patient-Specific Plan(s):

Labor Precautions, Daily Fetal Kick Counts recommended, RTC in 1 week, NST/AFI 2x/wk, Consider induction

View Existing Notes OK Cancel Reset Help

Office [Icons]

Start [Icons] 3:27 PM

2250

2256

Fig. 22C

38/55

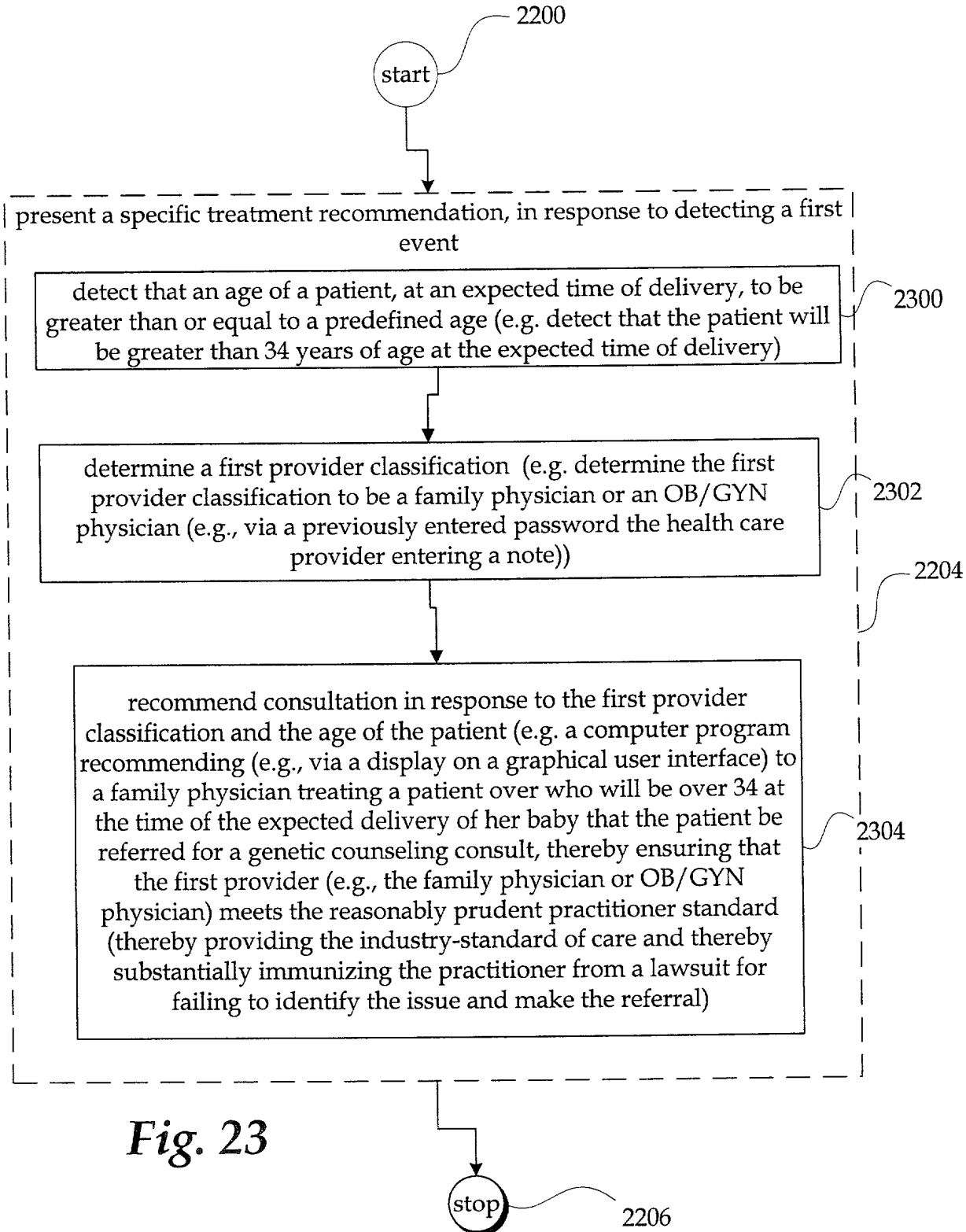


Fig. 23

39/55

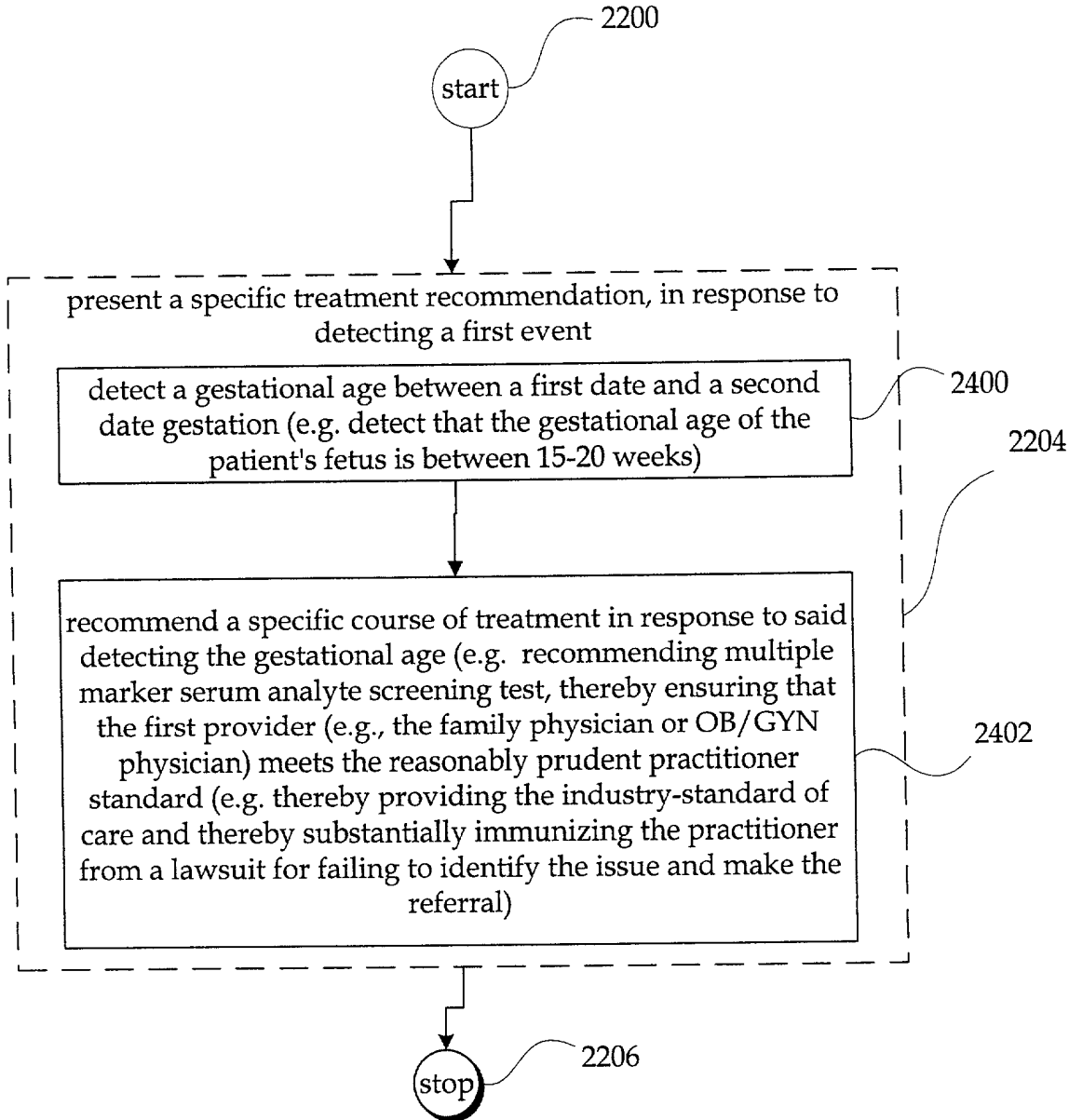
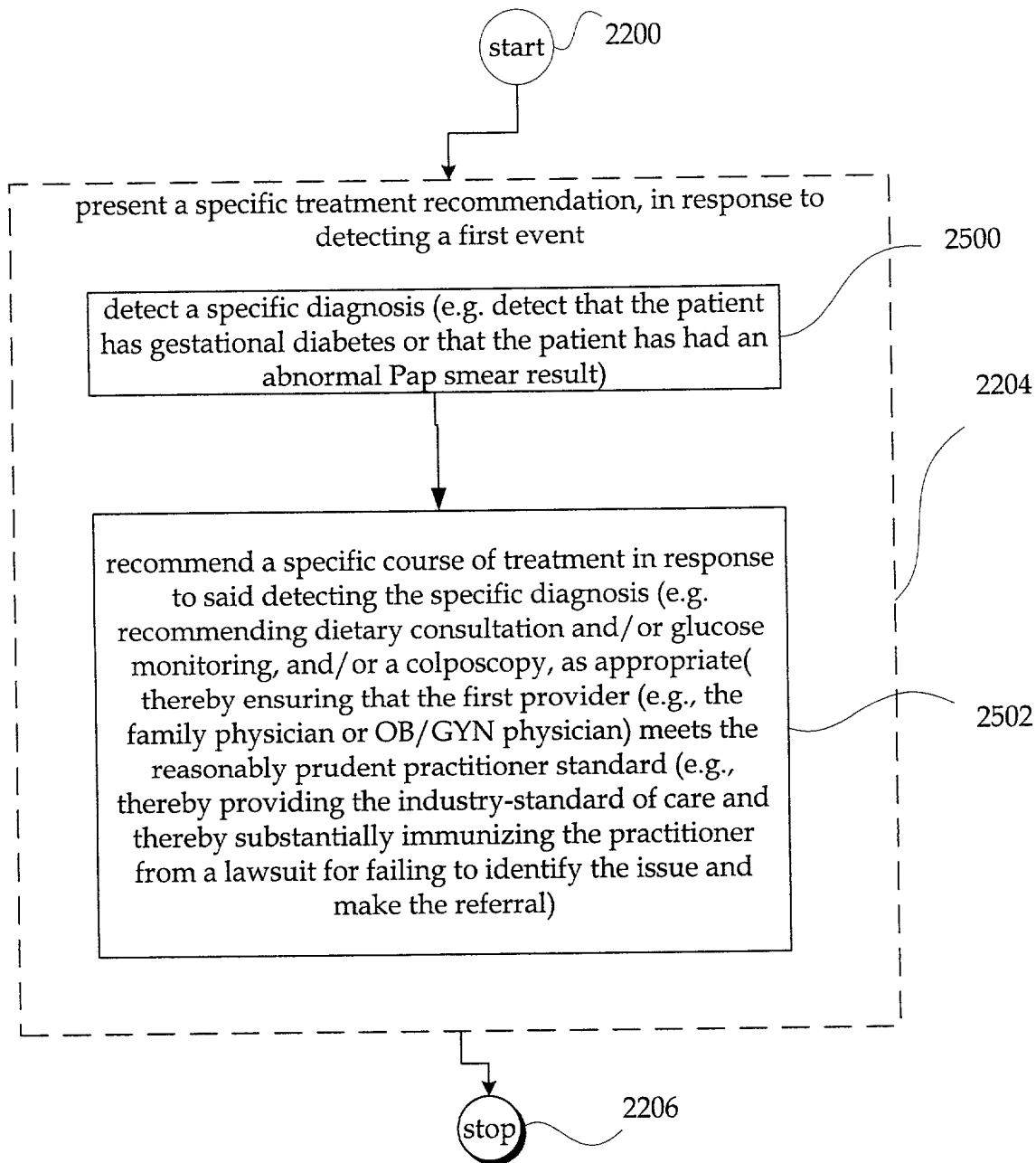


Fig. 24

*Fig. 25*

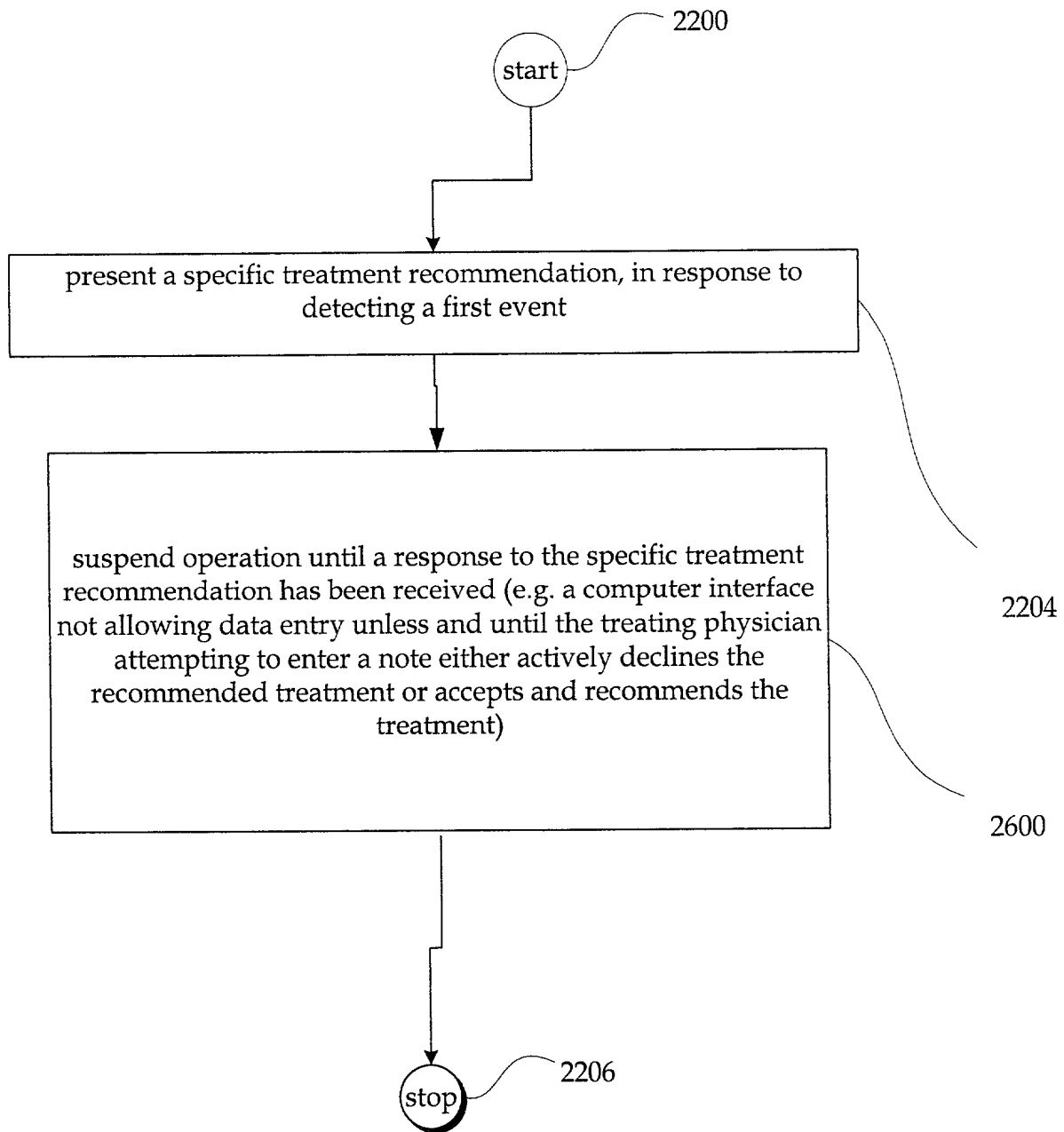
*Fig. 26*



Fig. 26A

43/55

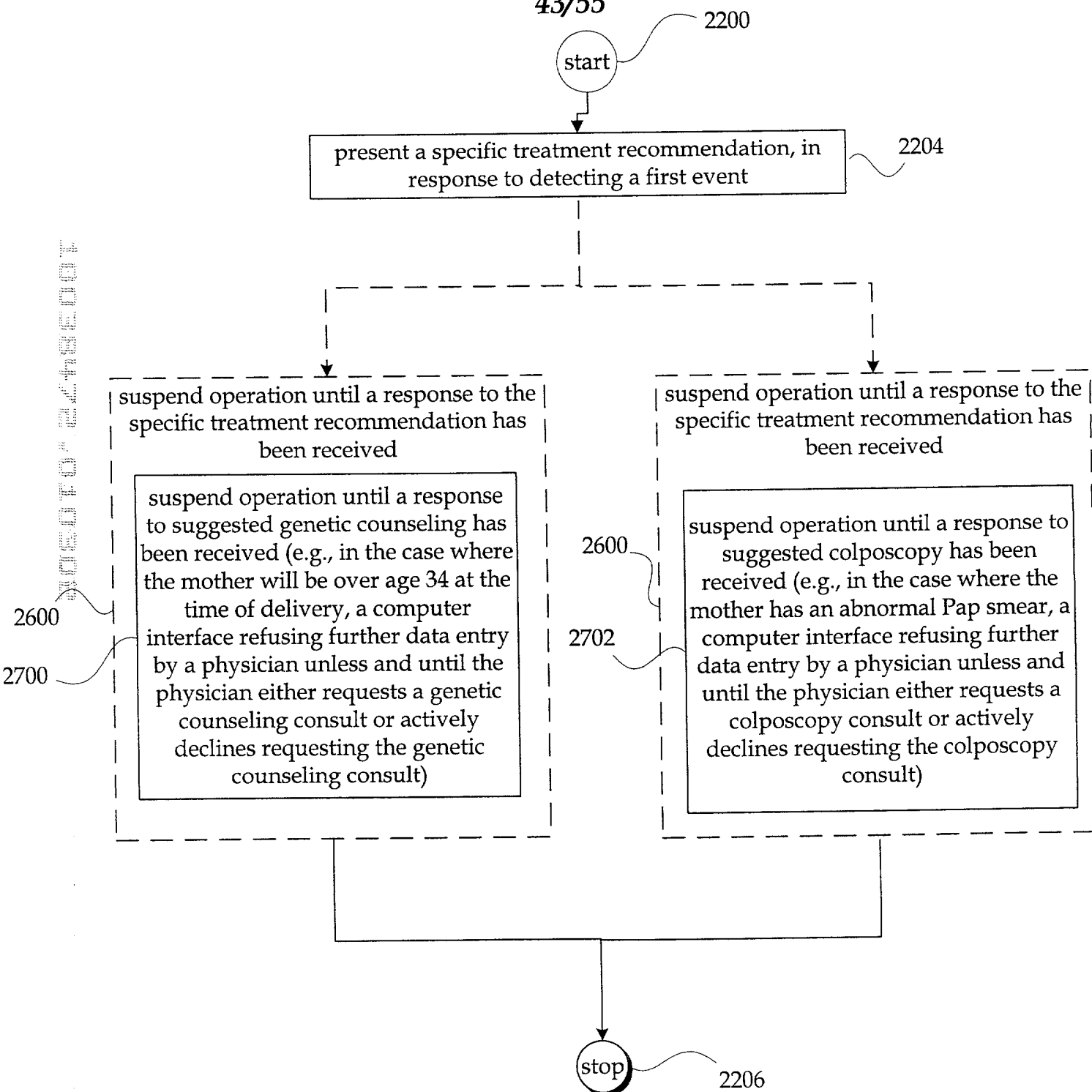
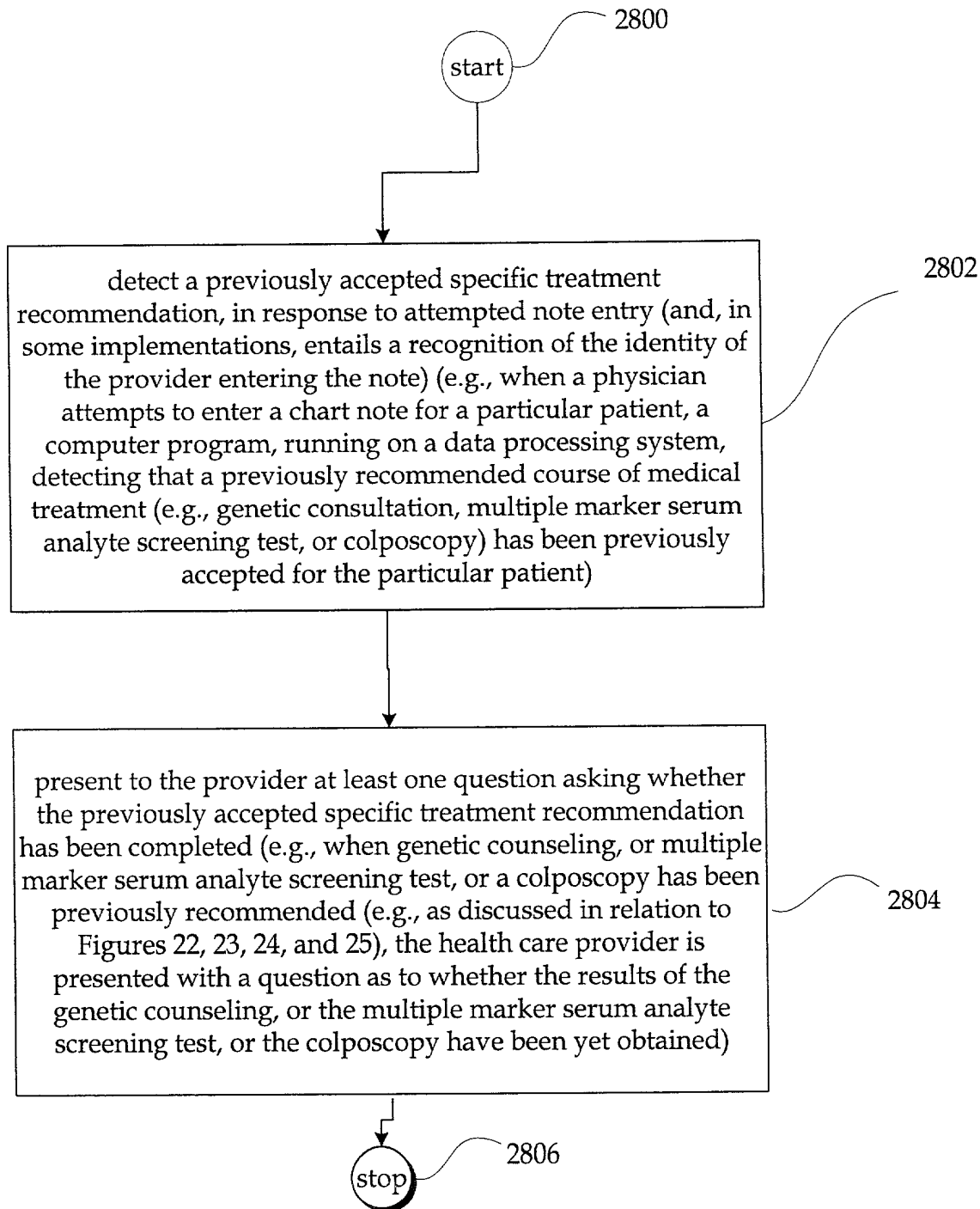
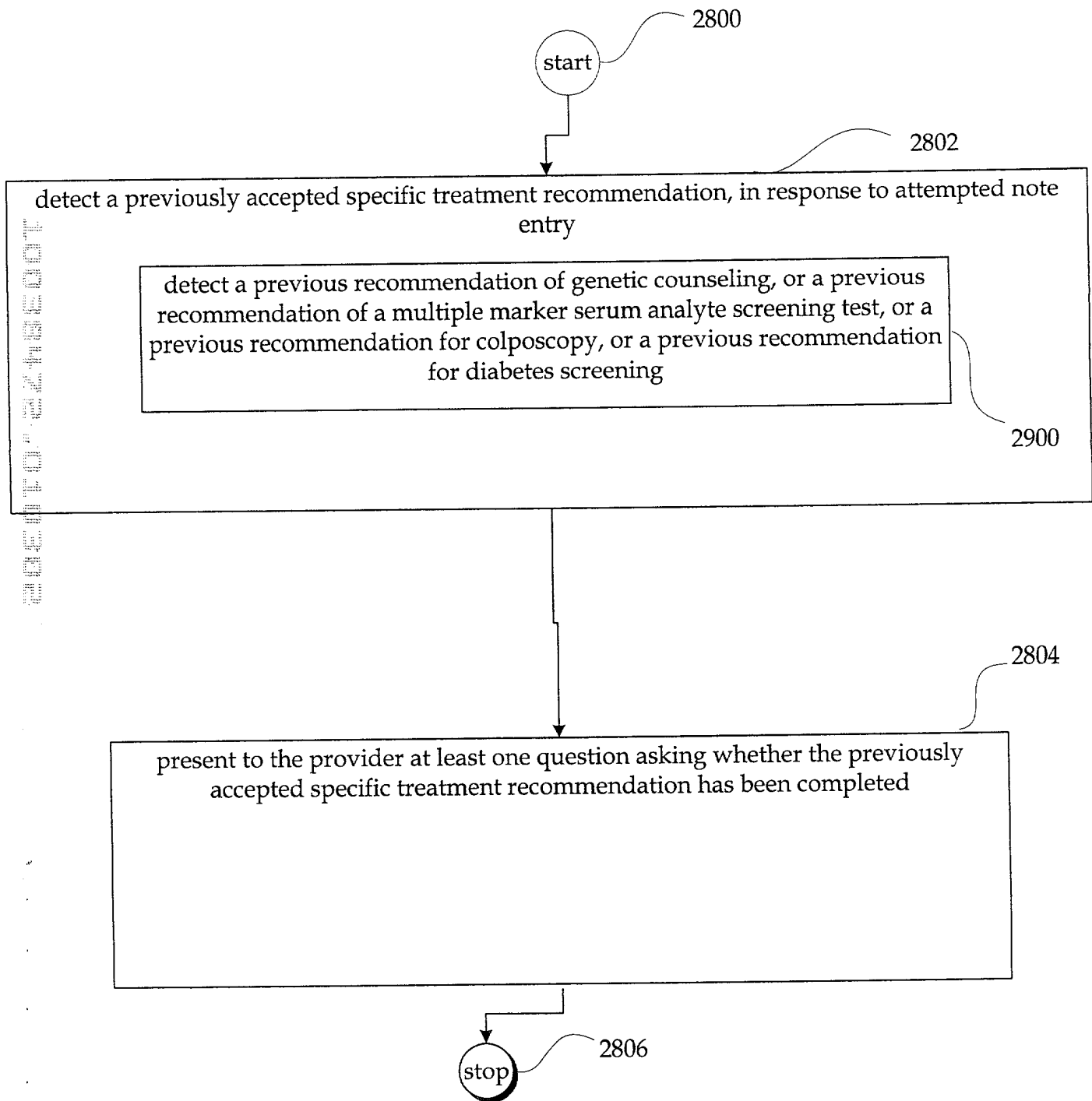


Fig. 27

*Fig. 28*

*Fig. 29*

46/55

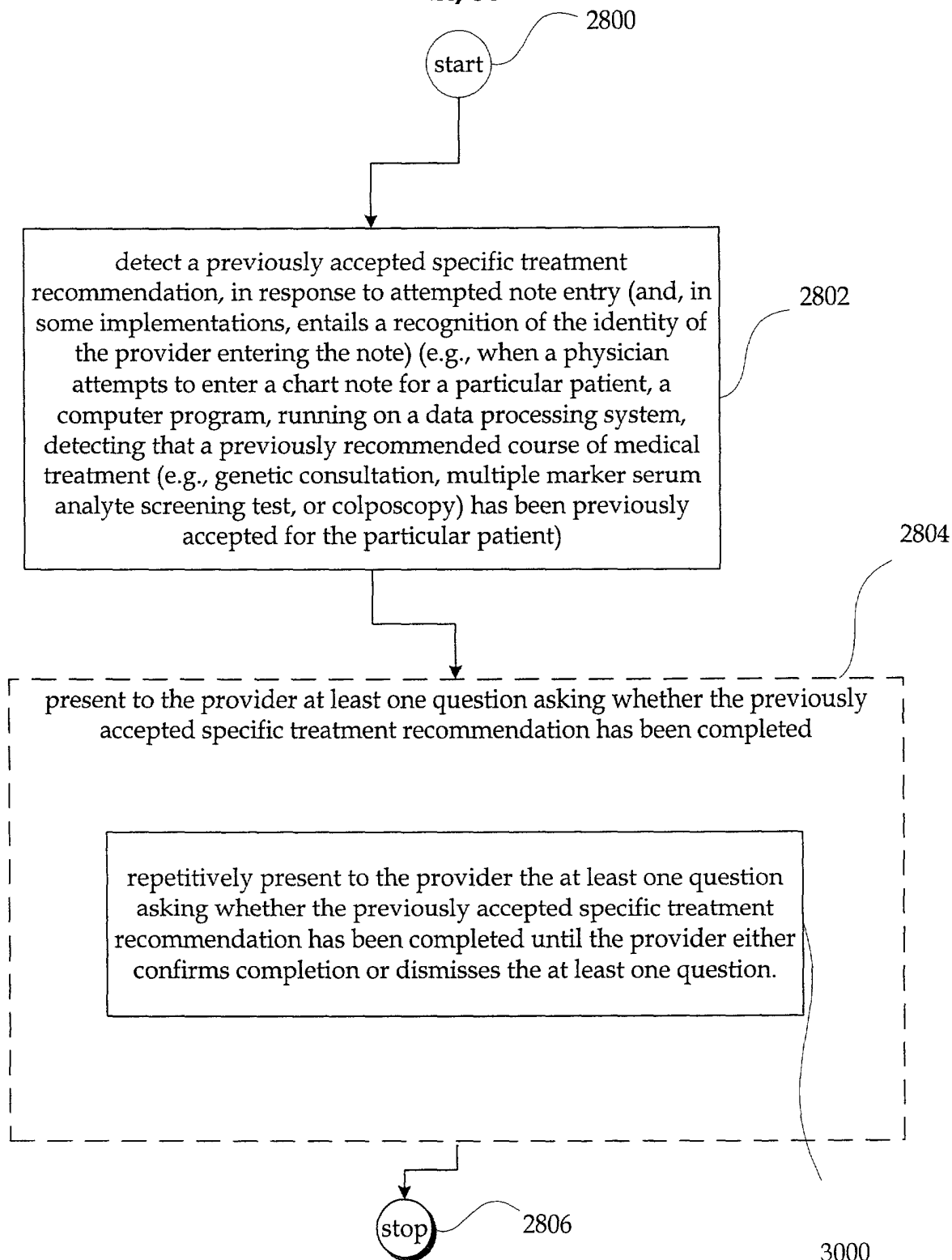
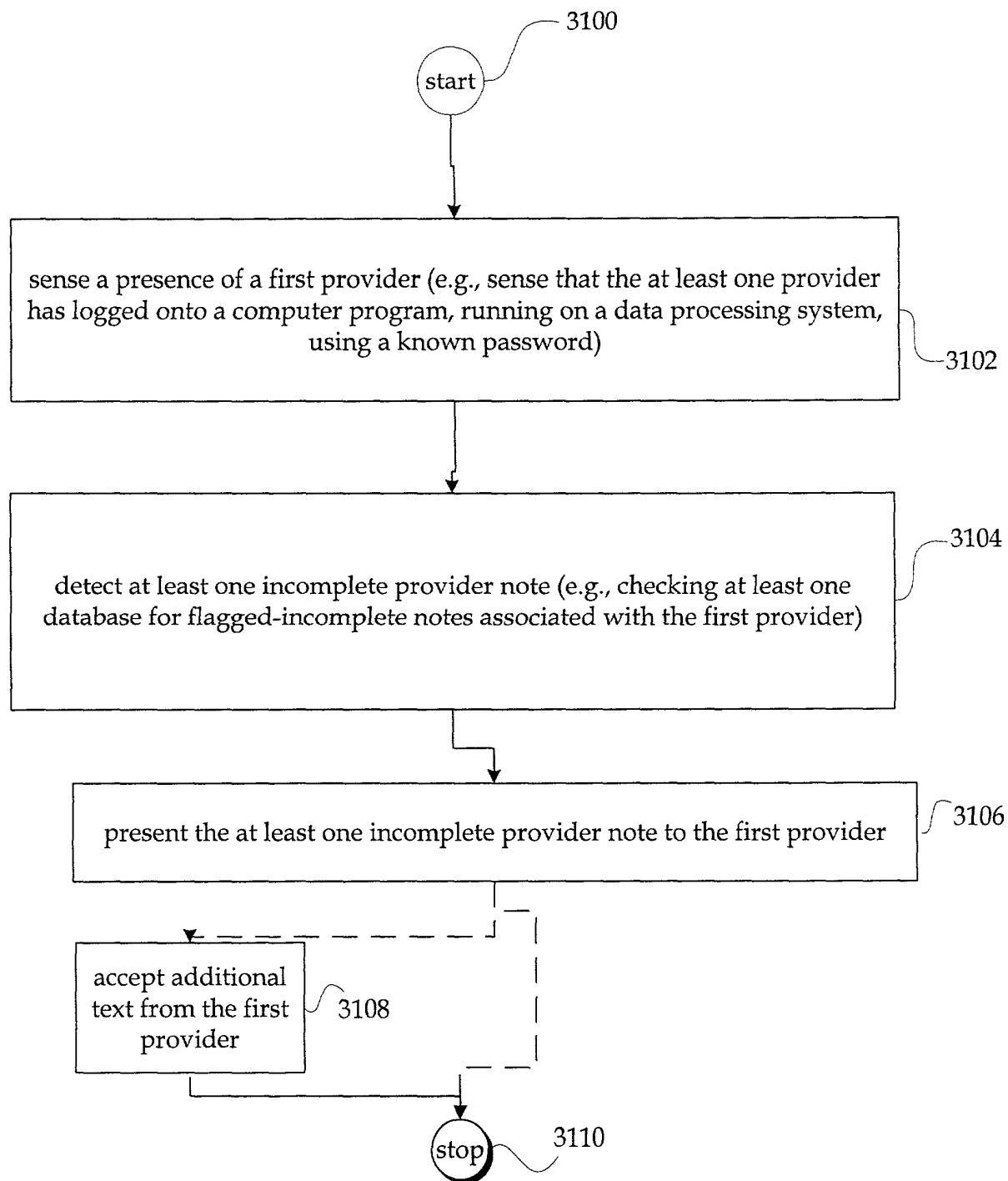


Fig. 30

*Fig. 31*

48/55

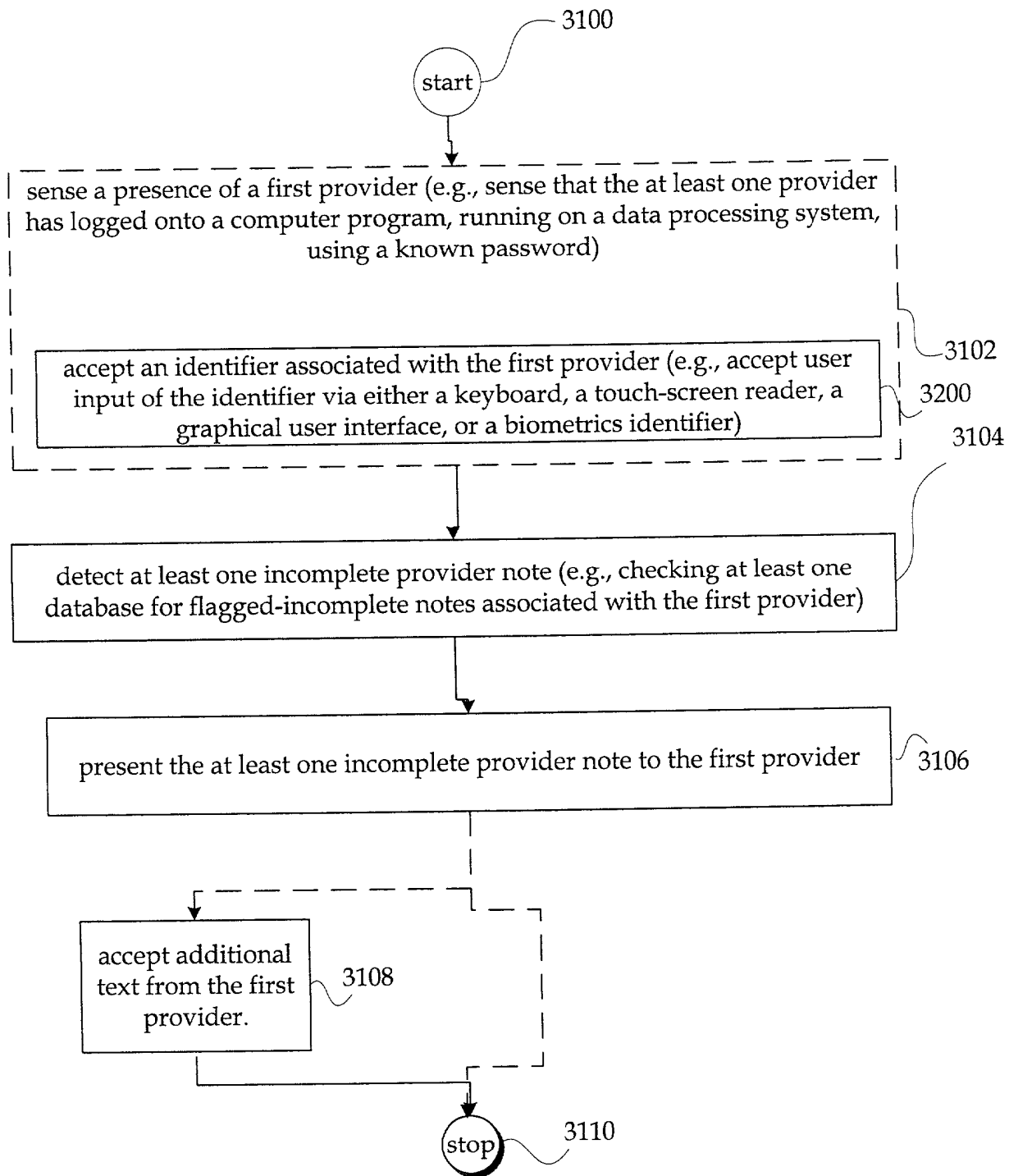
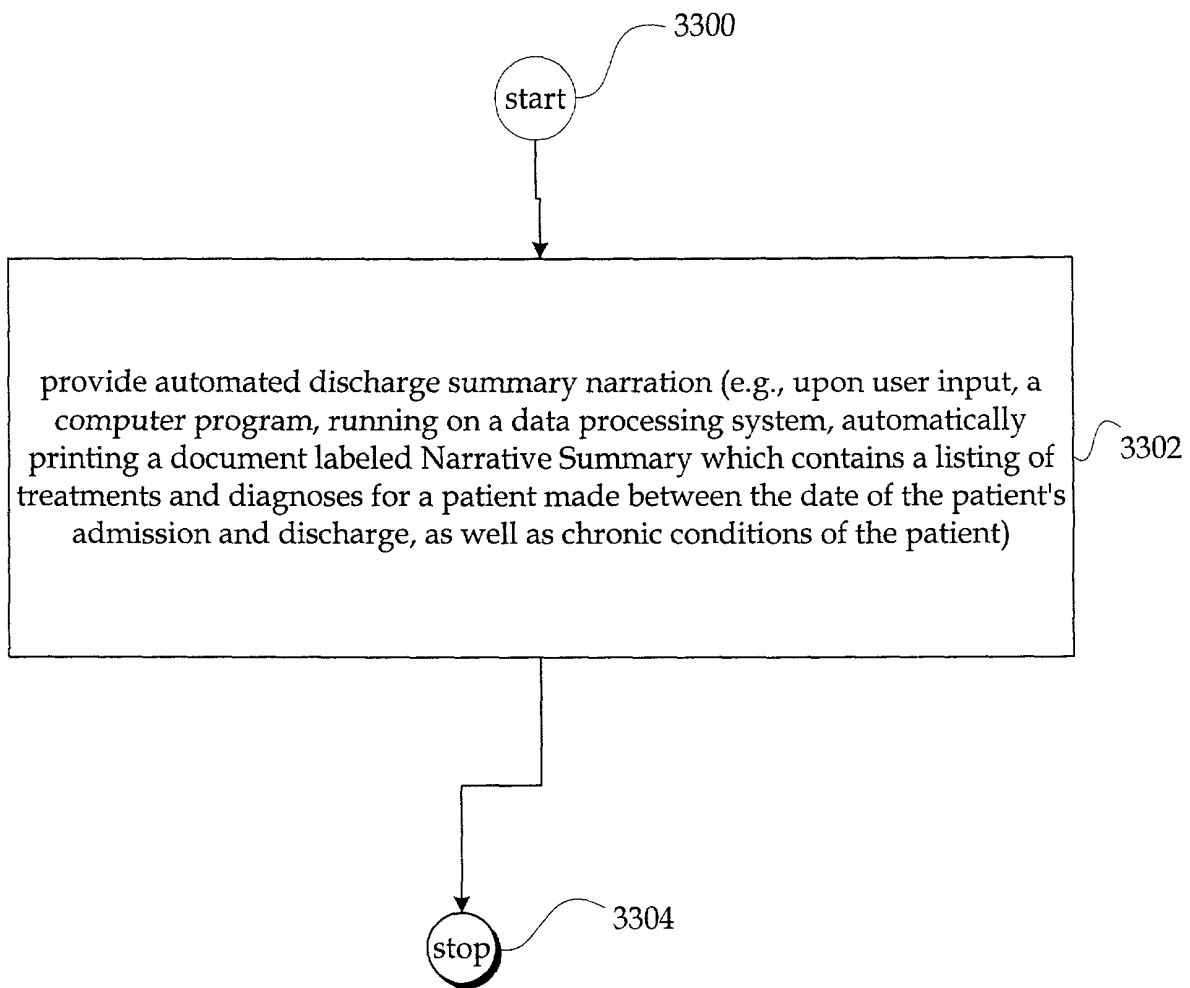


Fig. 32

*Fig. 33*

50/55

STORC - STandard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Proc Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38, 0/7 Type/Rh: A+ STD LABS NKDA

Discharge Summary Refresh Findings/Diag/Proc Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Prior Admissions/Discharges

Admit Date	Disch Date	Review Date/Time	Rt
23 Nov 2001	23 Nov 2001	25 Nov 2001 0900	ev

Delete Discharge... Total: 1

Discharge Date: 25 Nov 2001 Time: 0900 Discharging Phys: drmann

Admission Complaint/Reason(s) Comment

RUPTURE OF MEMBRANES

Final Diagnosis Summary: (This will show as delivered if there is a Stage 3 Date)

38 week/0 day IUP, delivered 1 Liveborn, FEMALE weighing 3560 gms with apgar scores of 8/9 Delivery via SVD

Procedures Performed:

Procedures:

- AUGMENTATION OF LABOR, OXYTOCIN
- EPIDURAL
- FENTANYL
- FETAL SCALP ELECTRODE
- FOLEY PLACEMENT
- INTRATHECAL ANESTHESIA
- MIDLINE EPISIOTOMY

(Note: If delivery was an Extrauterine Pregnancy and it is shown as an IUP, you must add Extrauterine Pregnancy to the Pb List or Compl screen and then click Refresh)

Occ Screen... Mark Reviewed/Save/Close Save/Close Save Cancel Reset Help

Office

Start Slide Inbo CD Inbo CHC CHC FW RE W Mot ST... 2:16 PM

Fig. 33A

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: **DELIVERED-CURRENT**

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 D/7 Type/Rh: A+ **STD LABS** **NKDA**

Discharge Summary Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Significant Findings From Admission:

Finding/Health Condition	Type	Comment
CEPHALIC PRESENTATION	PRESENTATION	
LABOR, LATENT	ADMISSION	
NO LACERATION	LACERATION	
SROM (SPONTANEOUS RUPTURE OF VAGINAL DELIVERY)	ADMISSION	
	DELIVERY TYPE	

Note: To add/delete items for the significant findings and procedures lists, use the Problem List, Complication, and/or Procedure screens.

Office Screen... Mark Reviewed/Save/Close Save/Close Save Cancel Post Help

Microsoft

Start Slide Info CD Info CHC CHB FW RE Micr ST... 2:16 PM

Fig. 33B

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STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: **DELIVERED-CURRENT**

COMPLICATED Age: 35 G/P: 7/0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A+ **STD LABS** **NKDA**

Discharge Summary

Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Significant/Chronic Findings from History

Finding/Health Condition	Type	Comment
ADVANCED MATERNAL AGE	ANTEPARTUM	
ADVANCED MATERNAL AGE	HISTORY GENERAL	
ADVANCED MATERNAL AGE	VISIT ASSESSMENT	
LEEP	ANTEPARTUM	SURGICAL Hx - Cervix > 4 cm on 4/26/01
SINGLE PARENT ACTIVE DUTY	ANTEPARTUM	No plan of marriage-FOB - min involved
STERILIZATION, DESIRED	ANTEPARTUM	

Note: To add/delete items for the significant findings and procedures lists, use the Problem List, Complication, and/or Procedure screens.

Occ Screen Mark Reviewed/Save/Close Save/Close Save Cancel Reset Help

Office

Start Slide Info CD Inba CHC CHC PW RE Mic ST 2:16 PM

Fig. 33C

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20030420 1030

STORC - STandard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN **Disposition: DELIVERED-CURRENT**

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest. Age: 38 0/7 Type/Rhr: A+ **STD LABS** **NKDA**

Discharge Summary Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Discharge Medications

Medication/Drug Name	Entered By	Entered	
<input checked="" type="checkbox"/> VITAMIN PRENATAL (PNV)	ewhiggin	23	Add
<input type="checkbox"/> Motrin (Ibuprofen)	ewhiggin	23	
<input type="checkbox"/> Colace	ewhiggin	23	Delete
<input type="checkbox"/> Iron	ewhiggin	23	

Add Standard Meds

Other Instructions: Select Std Instruction: NSVD Comp VD C/S PTL Previa

Pelvic rest (no intercourse or douche) for 4-6 weeks
 Return for evaluation of temperature >100.5, bleeding > menses, vomiting, pain, foul discharge
 Pencilare for episiotomy if applicable
 Avoid tub bathing for 2 weeks
 Return to gentle exercise/activity in 2 weeks as tolerated

(Note: The Condition, Limitation and Diet values will be set to the appropriate defaults when one of the std instructions is selected.)

Condition on Discharge: STABLE, DELIVERED

Limitations on Activities: PELVIC REST FOR 4-6 WEEKS

Diet: REGULAR **Narrative Summary Dictated?** Yes No

Follow-Up Instructions

Return to: RAMSTEIN Facility

OB/GYN Clinic

In 6 Weeks Days

Doc Screen Mark Reviewed/Save/Close Save/Close Save Cancel Reset Help

Office

Start Side Inbo CD Inbo CHC CHE FW RE Mic ST 2:17 PM

Fig. 33D

ATTORNEY CLIENT PRIVILEGED AND/OR CONFIDENTIAL

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STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDE: 06 Dec 2001 Gest Age: 38-0/7 Type/Rh: A+ STD LABS NKDA

Discharge Summary

Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Enter any additional comments in the space provided below. If the comment can be recorded/entered elsewhere on one of the Discharge screens, you should use that space/method in order to make the data available for future analysis and research.
(Maximum length of text is 255 characters)

Doc Screen Mark Reviewed/Save/Close Save/Close Save Cancel Help

Office

Microsoft

Start Side Info CD Info CHC CHC FW RE BY Micr SI 2:18 PM

33E

ATTORNEY CLIENT PRIVILEGED AND/OR CONFIDENTIAL

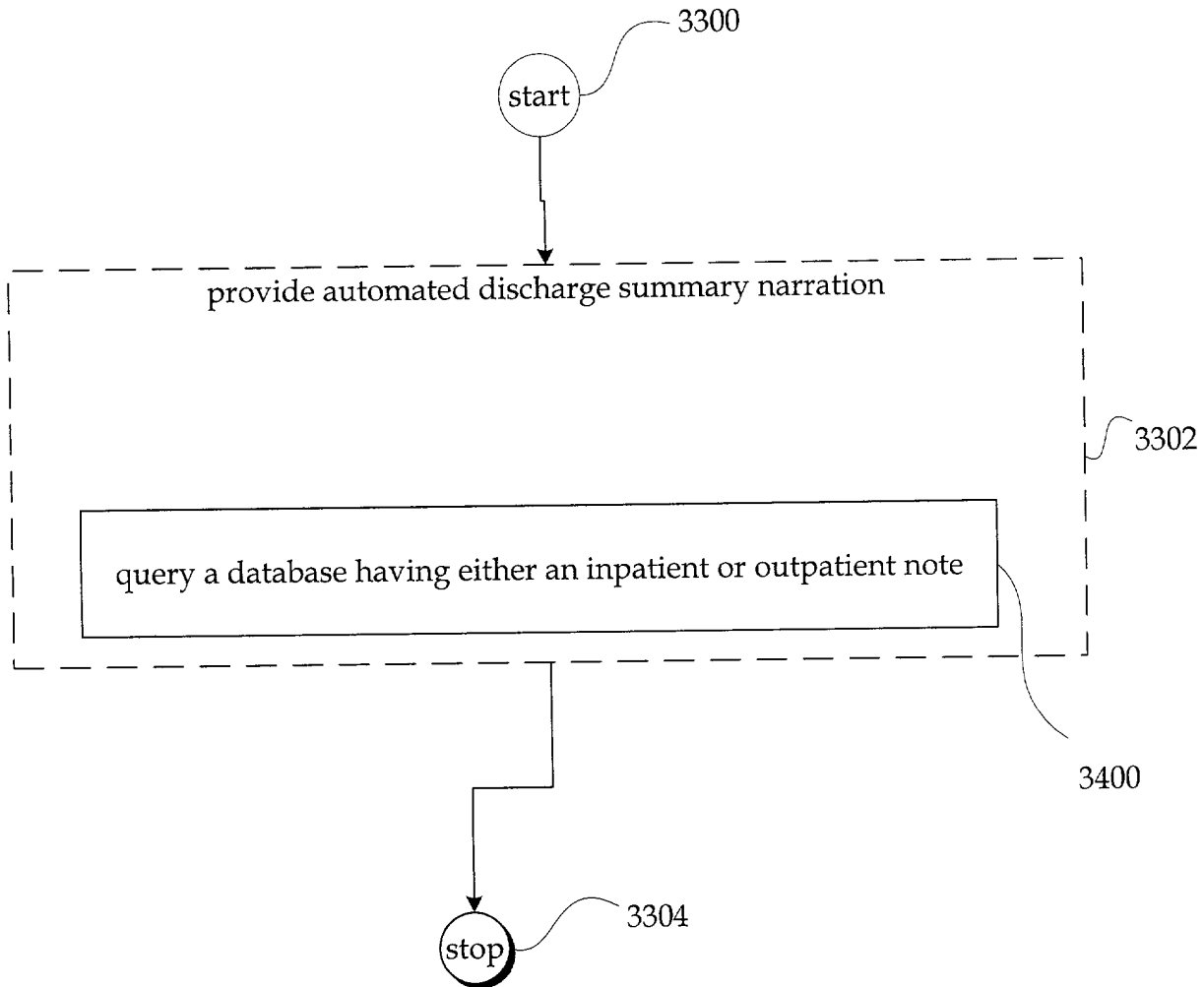


Fig. 34